

## Medical Critique

The Second of a Series by John McEachern, M.D., F.A.C.P., F.R.C.P. (Can.)

### II. On Heart Sounds and Murmurs

One hesitates to add to the confusion and chaos which has plagued this subject for 130 years. The medical literature dealing with this matter is haunted by redundant and useless opinions, some of them generations old.

Of late, the use of sensitive instruments for recording cardiac sounds has added to the turmoil. Sounds too weak to be heard by the human ear are being recorded, glibly described and written into the record.

From the clinical point of view there are just two important heart sounds, the first and the second. We might be better employed in mastering the secrets of these two sounds than by cluttering up our memories with unheard whispers. In table 1 some of these extraneous "sounds" are enumerated. A few of these are of clinical importance and a few can actually be heard by the human ear. The rest may well be forgotten.

Table 1.

1. The third heart sound.
2. The fourth heart sound.
3. Semi lunar opening click.
4. Mid systolic click.
5. Summation gallop rhythm.
6. Physiological third heart sound.
7. Opening snap of mitral stenosis.
8. Water wheel murmur.
9. Splashing sound.
10. Pericardial knock.
11. The crunch of mediastinal emphysema (this one is of real interest).
12. Systolic gallop.
13. Protodiastolic gallop.
14. Protodiastolic pericardiac vibration.

No one will decry the earnest efforts of the physiologists in discovering and classifying such nebulous heart sounds. There is also a hope that in good time the careful visual registration and study of these components will contribute much to our knowledge. **But is it helpful to introduce these to clinical medicine when they cannot even be heard by methods in general use?**

The intensity of the two important heart sounds is of modest clinical importance. The normal variation in intensity is very wide.

If we think of the heart as a somewhat noisy pump encased within a closed barrel, it is quite

easy to assume that factors affecting the cage, its medium and the pump itself may alter the intensity of the sounds. The cage wall or the epicardium may be thickened by fat, thus diminishing the intensity of the sounds. Fluid in the pericardium, of emphysema, may accomplish the same thing.

A large soft infarct of the anterior wall of the heart may muffle the sounds to a striking degree. The significance of an **increase** in intensity of the sounds is very slight. The sounds are loud in nervous, thin individuals, in hyperthyroidism and in hypertension. Of more significance is the loud slapping first sound that is heard in some cases of mitral stenosis—but it is only important if the other components of this clinical pattern are observed.

The importance of accentuation of aortic or pulmonary second sounds has been greatly overrated. If these are very loud, one may hazard a mere guess that the blood pressure is elevated in one or the other circuit.

It must be remembered, however, that an accentuated booming amphoric second aortic sound is one of the earliest signs of syphilitic aortitis. Such a finding in a middle aged man should raise the index of suspicion.

It is obvious that alteration in the intensity of the heart sounds is of little clinical importance.

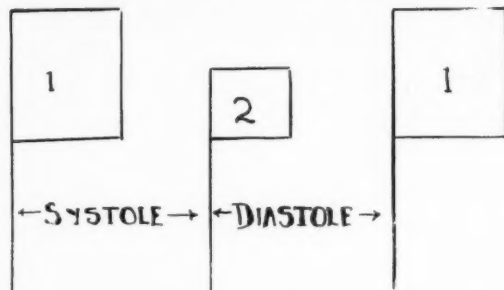
A few days ago an ex-serviceman applied for a pension. His doctor had diagnosed a "leaking valve," whatever that may mean, but a careful examination revealed no abnormality, not even a functional murmur. He was told that the heart was normal. "Oh," he said, "that can't be right. My doctor has an electric stethoscope with five switches. It wasn't until he turned the fifth button that he made the diagnosis."

One feels sure that many stethoscopes in use contain a "built in" murmur, but heaven help us and the patients if they produce one with five!

In the study of murmurs the points to remember are the timing, pitch and intensity in order of importance.

Timing is not difficult if the murmur is related to the heart sounds themselves. Timing by palpation of the apex beat or by the carotid artery is not a very satisfactory method. A few murmurs may be memorized as one "learns a dog's bark" (Lewis) notably mitral stenosis.

The following diagram shows the time relationship between the first and second sounds and the systolic and diastolic phases of the cardiac cycle.



A murmur occurring anywhere after the beginning of the first sound and before the beginning of the second sound is systolic in time. Diastolic murmurs may occur during any part of the succeeding phase. These are the most difficult to hear because they are usually soft and high pitched. Exercise and change of position may help to bring them out. **Diastolic murmurs mean organic valvular disease.**

There are only two diastolic murmurs of any importance, the one associated with aortic regurgitation heard best in the third left interspace and replacing the second sound.

The other is the variable one of mitral stenosis occurring anywhere during the diastolic cycle, usually heard just inside the apex beat. The common murmur in cases of mitral stenosis is loud and crescendo followed immediately by a loud slapping first sound.

To illustrate what is meant by clinical patterns: The parents bring in a thirteen-year-old child for examination. They have been told that she has a "leaking valve." They are worried and anxious. The child is said to have become blue occasionally when she has had a severe cold and cough, but there are no other symptoms.

On examination there is quite a loud systolic murmur heard best at the third left interspace. This murmur is grade four on the basis of one to four—murmurs of grade three and four intensity are more likely to be of organic origin than the softer ones. On palpation a marked thrill is felt at the same location. One may now be satisfied that the lesion is organic.

On fluoroscopic or X-ray examination the right ventricle is enlarged or the heart is somewhat

globular in shape. The electrocardiogram is inconclusive. The presence of a loud murmur, a definite thrill and a globular heart mean organic disease. The lesion is not uncommon. It is a patent intraventricular septal lesion (congenital). The functional capacity of the heart is excellent.

The prognosis is excellent. The parents may be reassured but warned of the danger of removing septic teeth or tonsils without previous chemotherapy. Subacute Bacterial Endocarditis sometimes strikes at the site of the lesion.

I have records of eight servicemen seen recently who had definite soft aortic diastolic murmurs with no high pulse pressure signs usually seen with aortic reflux. These murmurs are not uncommon and are frequently missed.

It is obvious that one can make a definite anatomical diagnosis of a lesion of a specific valve if one can recognize a diastolic murmur. Not so with the systolic murmur. Try it (and it is tried all too often) and you will be from 50 to 75 per cent wrong.

No systolic murmur should ever be labelled as organic without other clear cut evidence of heart disease. If the murmur cannot be fitted into one of the clinical patterns characteristic of a specific valvular lesion, it is most likely functional. If the physician is not able to make an etiological and anatomic diagnosis after he hears such a murmur, it should be recorded as physiological.

My final point is that if one hears a systolic murmur, one should at once ask the following questions:

1. Is it organic?
2. Are there any other signs of heart disease?
3. If so, what is the location of the defect?
4. Is it an obstructive or regurgitant lesion?
5. What is the cause of the lesion? (rheumatic, etc.)
6. What is the functional capacity of the heart muscle?
7. Has the patient had a thorough cardiovascular survey before being convicted of having organic disease?

If the physician cannot answer any one or all of these questions he is better not to make any diagnosis at all.

This should reduce the number of cardiac neurotics floating around the country by about 50%—a worthy objective.

## The Reduction of Neonatal Mortality

Joseph Graf, M.D., Mod. Dipl. Paediatrics

One of the most important pediatric and public health problems of the past decade has been the high neonatal mortality rate. Pediatricians all over the world have been directing their efforts toward a better understanding of the physiological and pathological peculiarities of the new born as a first necessary step toward the reduction of this excessive morbidity and mortality rate. Definite progress has been made and as the practical implications of these advances can be carried to the smallest rural centers, I believe that this will be of great interest to you for most of you practice in small communities.

As the time at my disposal is short, I shall try to give you quickly a picture of the new findings and ideas, leaving it to you to find the details in books and journals once your interest in the subject has been aroused. Obviously it would be quite impossible to discuss the whole problem academically, but points not mentioned can be brought up in the question period.

The transition from intra-uterine to extra-uterine life is a dramatic one and most important changes occur in the organism of the infant, who finds himself in a strange environment and exposed to new influences to which he has to adapt himself. Thus you will find that certain pathological processes can be regarded as the immediate consequence of the birth process. In another group of affections what may be considered physiological phenomena have developed to pathological proportions. Most important are those diseases which, because of the physiological peculiarities of the newborn, occur only in the first weeks of life.

Various statistics will give different data regarding the order of precedence of the causes of neonatal death, but without any doubt prematurity, developmental malformations, intracranial injuries, asphyxia and infections are the leading ones followed by erythroblastosis foetalis and other less frequent causes.

Prematurity is a direct cause of practically one-fourth of all infant deaths under one month of age, and is a contributing factor in at least an additional fourth. It used to be said that the maintenance of constant heat is the main factor in caring for a premature baby. Today we know that a proper degree of humidity is just as important and so also are the prevention of dehydration and infection. The premature child is inclined to develop acidosis and therefore his electrolyte requirements should be well cared for. No effort should be spared to give him breast

milk, but the caloric intake is not the primary concern as the metabolic rate of the premature is very low. To remedy this and to help the maintenance of heat many pediatricians give small amounts of Dessicated Thyroid. The instability of the heat regulating mechanism during this period is well known. The fact that premature infants show defects in sucking and swallowing as well as in the cough and gag reflexes should be kept in mind when feeding the child. If the infant is very small it may be advisable to forego all oral or gavage feedings and administer both salt solutions and glucose parenterally. Vitamin K should be given to every infant immediately after birth and should be repeated at least twice during the first week. As these children are born with low vitamin C stores, this vitamin should be given daily in generous doses in addition to vitamin D. Recently several articles were published about the use of both male and female sex hormones to stimulate the growth of premature children but there is no conclusive evidence available regarding their value and I certainly would not advise their use until further data are obtained.

As a last word about prematures I wish to give you the modern concept and definition of prematurity which differs from old text book definitions. "A premature infant is one who weighs five and a half pounds at birth regardless of the period of gestation." The inference is that infants classed as above are not completely prepared for full normal independent extra-uterine life.

As I have mentioned, developmental deformities occupy a leading position among causes of death during the neonatal period. It seems that we are going to know more and more about the etiology of these malformations. Warkany's work is most interesting in this field. He has repeatedly shown that the removal of certain elements from the diet of pregnant animals always resulted in the same type of malformation in the offspring. Work done in Toronto has similar implications regarding the importance of diet as a preventative factor of developmental malformations. The effect of some of the infectious diseases of the mother on the foetus has been known for a long time, but only recently we have learned that rubella occurring prior to the third month of pregnancy causes very serious developmental malformations.

There is still a long way to go before we reach a clear understanding of this chapter of pathology, but I am hopeful that progress will be made in the not too distant future.

Intracranial injuries occur much more frequently than they are diagnosed. Infants who die from intracranial hemorrhage are often believed to have died from enteritis which usually is secondary only. Bundenson and his co-workers by comparing causes of death given in a group of cases without autopsy with those given in a group in which autopsies were performed, found that in the latter group the incidence of intracranial hemorrhage was twice that of the group without autopsies while prematurity occurred only half as often. This shows not only the frequency of intracranial hemorrhage, but also the importance of postmortem examination of infants dying in the first few days of life in any effort to reduce the mortality rate. Autopsies provide the most useful material for a better understanding of the problem. A number of factors take part in producing the so-called intracranial injuries. Gross trauma is an important one, but there are many extrinsic and intrinsic factors which may damage the vascular system. Deficiency in vitamins C and P, circulatory disturbances, prolonged analgesia with the resulting anoxia and various capillary toxins can all produce weakness in the vascular endothelium and initiate bleeding. However, most clinically significant hemorrhage is due to a defect in the clotting mechanism. This is exactly the case in the neonatal period when there is a marked decrease of prothrombin in the blood plasma which does not reach a normal level until after the seventh day. When Dam in 1934 discovered a substance called by him vitamin K which prevented bleeding due to hypoprothrombinemia in chickens, he contributed a great deal towards the reduction of hemorrhage in the newborn. This vitamin given to mothers by mouth for three to five days, or parenterally at least two hours and not earlier than twelve hours before delivery, will restore circulating blood of the infant and thus an all-the normal percentage of prothrombin in the important factor in the production of hemorrhage is removed. Today the chemical nature of this vitamin is known and the synthetic products on the market can be obtained for a few cents; therefore no child should be deprived of the benefit of this discovery.

Chemotherapy made great advances in the last decade in combating various infectious diseases, but infections still cause the death of many thousands of infants during the first weeks of life; therefore emphasis should be placed on preventative measures. It is a well known fact that infectious diseases of the newborn are much more common in crowded hospitals than in homes. We all know that the child after birth is supposed to possess a fairly high degree of immunity inherited from the mother. However, the fact

stands, that most of the infections during this period of life are caused by organisms of relatively low pathogenicity. Infections of the skin are very often the starting points of more serious conditions; therefore, in an attempt to prevent pyodermias a number of pediatricians have been advocating the routine use of 5% sulfathiazole ointment over the skin of the infants. Weymuller found the results excellent and states that no sensitization was encountered by him. I would not advise this procedure as a prophylactic measure and my attitude is the same regarding the oral or parenteral use of various sulfa drugs in the prevention of infections in the neonatal period, unless a very definite indication exists. Dooley and Henley have used chemotherapy as a preventative measure in prematures and have not met with harmful results . . . as yet. The most important steps are still the old standbys: As soon as a newborn gets ill, he should be isolated from the other infants in the nursery and should be cared for by a different personnel. I realize this is often impossible but still it should be the goal. No one should ever touch the baby without proper hand care before doing so. The importance of wearing masks is still a debated question, but it is essential that the personnel in charge should be free of infections including "mild colds." The so-called epidemic diarrhoea of the newborn appears at various intervals in different localities. Whether it is a disease entity caused by a specific organism, possibly a virus, is still a debated question, but it causes death in a large number of infants so affected. Sulfaguandine and succinyl-sulfathiazole are used by many in treating this condition, but it does not seem that they have any advantage over sulfadiazine.

Asphyxia is one of the conditions which has been getting great attention from pediatricians in the past few years. There are new ideas about the physiology of the respiration in utero and the pathology of this condition is interpreted somewhat differently than it used to be. There is more and more evidence accumulating to indicate that the mechanism of respiration is functionally developed long before birth and more or less co-ordinated respiratory efforts take place in utero. Therefore the actual initiation of the first post-partum breath makes use of a mechanism which already exists and, to a limited extent, actually functions. Anything which will interfere with the continuity of this function may cause asphyxia. The most important causes of failure of initiation of post-partum breathing, or of adequate respiration, lie in the brain itself, sluggish in its action either because of narcosis or trauma. Less important causes lie in the thorax. Without any doubt the increasing and improper use of deep



analgesia and anaesthesia for delivery of infants has been accompanied by a corresponding increase in the incidence of death from asphyxia. Although most authors believe that asphyxia in the newborn is purely the result of anoxia there is some suggestion that traumatic shock is also an important factor. We should remember that prolonged asphyxia with resulting anoxia may cause permanent damage to the central nervous system. Studies of adults with mental defect or neurological pathology have revealed as many as 70% with a record of neonatal apnea. Once more the emphasis is on prevention. The essentials in treatment of asphyxia neonatorum are gentleness, warmth, cleaning of the upper air passages and an adequate supply of oxygen. A tracheal catheter is often life saving. De Lee stated once that of all the resuscitation equipment the tracheal catheter takes first rank. "Without it the most majestic machines are futile and with it they are hardly necessary." It is good to remember that initially the respiratory centers suffer from oxygen deprivation and not from want of carbon dioxide, but after an adequate oxygenation has been obtained some carbon dioxide may be added for stimulus to the centers.

My time is running short so I shall not speak to you about erythroblastosis foetalis. Most of you have heard Drs. Levine's and B. Chown's lectures about the subject last fall and those who were not present likely have read it in the Manitoba Medical Review. A great chapter has opened with the discovery of the Rh factor and its relation to E. F., from which many more infants died than was commonly thought. Since Rh negative blood transfusions were introduced dramatic results have been obtained.

Tetany of the newborn is met not infrequently if properly diagnosed. It is known that it tends to occur more frequently in severely traumatized infants. Symptoms are: hypertonicity, fibrillary

tremor or even convulsions, high pitched cephalic cry, inspiratory stridor, apnea, cyanosis, and the other classical signs of this condition. Death may occur promptly, likely from cerebral edema if treatment is delayed; response to parathyroid extract is often dramatic.

According to various statistics about 30% of all pregnancies complicated by diabetes mellitus result in death of the fetus or of the newborn. The high mortality rate is not related primarily to the severity of the maternal diabetes, as there is evidence that neonatal mortality is very high, long before mothers develop signs of diabetes. We know very little about the mechanisms of this condition and the only thing we can do is to give the best supportive therapy to the newborn, who is usually not suffering from hypoglycemia as used to be taught. There is a suggestion that blood sugar determinations should be made early in pregnancy and should constitute a part of antepartum examination so that any increased blood sugar level might serve as a warning sign and prepare us for the possibility of complications in the newborn.

Before concluding I wish to emphasize that the reduction of the mortality rate in the neonatal period is a problem for the obstetrician as well as for the pediatrician. The problem is intimately bound up with that of reducing premature births. Ante-partum treatment of the mother is as important as the post-partum treatment of the new-born. Every effort should be directed toward the elimination of possible difficulties developing during pregnancy, labor and delivery.

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## Maternity Hospitals of Greater Winnipeg

Ross Mitchell, M.D.

Now that the Winnipeg General Hospital has given priority in its building plan to a new maternity pavilion of 100 beds it is fitting to review the maternity hospitals of Greater Winnipeg from their beginning up to the present day.

In 1883 Winnipeg had a population of about 15,000 people. As a city it was small, but its hopes were as boundless as the surrounding prairies, and among its citizens there was a spirit of warm friendliness. In March of that year a group of Winnipeg women, headed by Mrs. W. R. Mulock, Mrs. J. A. M. Aikins and Mrs. George Bryce, founded the Christian Woman's Union. Their first act was to establish a hostel for young women earning their living in the city but away from their own homes. This hostel was first located in the old residence of A. G. B. Bannatyne on the Red River between McDermott and Bannatyne Avenues. Later it was moved to a house on Hargrave Street but it failed to attract young women of the class desired. The next service undertaken by the Union was to reopen the old Bannatyne house as a maternity hospital for unfortunate girls, poor married women and rural patients who might come to the city to secure good medical attention. For these latter there were four private wards. When the Bannatyne house was sold the hospital was moved to the large house of Sheriff Armstrong on May Street, near the present site of The T. Eaton Company warehouse. In 1886 it was again moved to the adjoining house of Major Morice. Although the aims of the Union were most praiseworthy, misfortune attended the ladies' efforts. Twice in the four years of operation there were outbreaks of puerperal fever, and although no lives were lost, the directors felt the heavy responsibility. About the end of 1887 they closed the hospital.

Their next step was to request the Board of the Winnipeg General Hospital to assume the operation of a maternity hospital. The hospital had moved to its present site in 1883-84, erecting a new building, part of which is still in operation as Wards A and B. A School for Nurses had been established early in 1887. The Board considered the request and declared as follows in the annual report of 1887.

"At present there is no room for such work, **which can only be cared for in a separate and isolated building.**" (Bold face ours.) "No result has yet been arrived at, but the Board are quite prepared to render every assistance in their power to provide, as part of the general work of the Hospital, a ward for maternity patients. This would add a great deal to the usefulness

of the School for Nurses and enable the Hospital to supply trained and skilled nurses for maternity cases and accidents as well as for all other kinds of nursing work."

### The Winnipeg General Maternity Hospital

With the aid of \$202.58 contributed by the Christian Woman's Union and grants of \$1,500 from the City of Winnipeg and \$500 from the Province of Manitoba, the Board erected a two storey brick building fronting on Olivia Street on the site of the northern end of the present Nurses' Home. Nothing illustrates better the spread between building costs of that day and the present than the statement in the annual report for 1888 that the building had been completed at a total cost of \$7,349.40. It was heated with hot water and had accommodation for fifteen public patients and four single wards for private patients quite isolated from the rest. Private patients could be attended by the physician of their choice and the charge for a private ward was \$2.00 per day. The report for 1888 is careful to state: "This building has been erected on the Hospital grounds, but upwards of 200 feet from the main building, with no corridor connection." The Board of that year feared infection from the main building, but a few years later convenience dictated the construction of a connecting tunnel which is still in use. The first medical staff of the maternity hospital consisted of Dr. H. H. Chown and Dr. J. S. Gray. The building was opened in December, 1888, in time to permit two babies to be born there in that year.

It was a weighty problem that the ladies of the Christian Woman's Union had laid before the Winnipeg General Hospital Board. In 1888 custom dictated that all women who could were delivered at home. This left for a maternity hospital only four classes—unfortunate girls, the destitute, rural patients who had no friends with available homes in the city, and those whose labours were expected to be extra difficult or hazardous. Little prestige to the hospital could be expected, and little revenue would accrue, but the Board met the challenge in a true community spirit. The new maternity building aided the city, the School for Nurses and the Medical School which had just graduated its first students. It was this hospital that made possible the clinical teaching of obstetrics.

In looking over the early annual reports one is impressed, however, with the slight importance attached to obstetrics. In those early years every doctor on the honorary attending staff was a general practitioner who was expected to turn

his hand to every branch of medicine. Later a distinction was made in the staff between medicine and surgery, but for many years the newly-appointed doctor would serve for a term in the outpatient department, then a term on obstetrics or infectious diseases before reaching the coveted goal of physician or surgeon. As the late Dr. O. Bjornson was wont to say, Obstetrics was the Cinderella of medicine. It was only about the turn of the century that the teaching of clinical obstetrics was conducted on the sane basis of choosing for that work men fitted by training and predilection for the position.

#### The First Caesarean Section

The first caesarean section on record in Winnipeg was performed in the Winnipeg General Hospital on Sept. 13, 1895. It is listed in the annual report of the hospital in the register of operations as "caesarean section necessitated by pelvic deformity." The operator was the late Dr. Andrew McDiarmid, and the assistant was probably the late Dr. J. S. Gray. The patient was Mrs. William Gordon, whose name appears in the register of admissions under date of Sept. 13, 1895, as Mrs. William Gordon, Presbyterian, 471 Dufferin Ave. A few lines below, but on the same date, appears the name Baby boy Gordon, 471 Dufferin Ave., with both Gordons under the care of Dr. McDiarmid. Dr. James Pullar, then a medical student, was an eyewitness of the operation which naturally aroused great interest in medical circles.

#### The Present General Hospital Maternity

In 1911 the little two-storey maternity was pulled down to make way for an extension of the Nurses' Home. It was in this year that the construction of the present five-storey building fronting on Bannatyne Avenue was begun. The Board of that year was of the opinion that existing maternity hospitals (Misericordia and Grace) could take care of Winnipeg's needs, but the attending staff protested. The result was that a temporary maternity hospital was fitted up in the Annex Nurses' Home, which is now incorporated into the Pathology building. When the new building was opened in 1912, the maternity hospital was moved to its present location in Wards West IV and West V. In 1920 a prenatal clinic was organized and continues to function. In 1913 the births in the Winnipeg General Hospital numbered 166; in 1945, 1,445.

That great obstetrical teacher, Dr. J. B. DeLee, believed that a maternity department situated within a general hospital carried a greater risk of infection than one which had its own separate building. If this view is correct, and there is much to substantiate it, the Board of 1887 was right

in erecting a separate building, and the Board of 1946 is equally right in returning to the decision to remove the maternity department from the main building.

#### Misericordia Hospital

The Institute of the Soeurs de Misericordia, founded in Montreal in 1845, sent four sisters to Manitoba in 1898. The first Misericordia Hospital was established in a house on the east bank of the Red, which now forms a part of St. Roch's Hospital. Dr. F. D. McKenty, then an interne in St. Boniface Hospital, delivered a young woman in that house for the late Dr. Lambert, pere. The second home of the hospital was a house on the southwest corner of Broadway and Carlton, where the sisters intended to lay the foundation of a permanent establishment, but unforeseen circumstances compelled them to abandon that site. A third location was secured near Maryland bridge and in 1900 the first part of the present structure was completed. One of the objects of the Institute is to help in the moral rehabilitation of the unfortunate victims of a deceitful world. Its motto is "Misericordia derelictis." Up to 1916 the hospital received only obstetrical patients, but in that year it became a general hospital.

#### Grace Hospital

Grace Hospital was organized in 1904 by the Salvation Army to care for unfortunate girls and to provide accommodation for maternity patients. For a time work was carried on in a rented house on Young Street. In 1905 the corner stone of the present hospital on Arlington Street and Preston Avenue was laid by the Hon. R. P. Roblin, Premier of Manitoba. In 1911 the hospital was enlarged, and in 1927 a fully modern fireproof building was constructed. About this time it became a general hospital. Rescue work is carried on in a separate building fronting on Evanson Street.

#### Victoria Hospital

Victoria Hospital in Fort Rouge was built in 1912 by the late Dr. Thomas Beath. A few years earlier Dr. Beath had built and operated a private hospital on Bannatyne Avenue, almost opposite the Medical College. This structure, now an apartment house, was used for a short time by the City of Winnipeg as a hospital for infectious diseases. One of the floors in the present Victoria Hospital is reserved for maternity patients.

#### St. Joseph's Hospital

The first unit of the present St. Joseph's Hospital on Salter Street was built in 1918 by the late Dr. Gerzabek as a private hospital. In June, 1923, it was taken over by the Sisters of St. Joseph from the parent house in Toronto. In

1927 a new fireproof unit was added. The Order of the Sisters of St. Joseph dates back to October 15, 1650, when it was established by the Bishop of Le Puy, France. The first Canadian foundation was at Toronto in 1851.

#### Concordia Hospital

The Mennonite Hospital Society started a maternity home in 1928 in a house on Machray Avenue. Later a move was made to Beverley Street, then in April, 1934, the red brick building on the Elmwood bank of the Red River was bought and named Concordia Hospital. It had been built some years earlier by the late E. F. Hutchings as a sanatorium. In 1945, 225 babies were born in Concordia Hospital.

#### St. Boniface Hospital

Although St. Boniface Hospital was the first hospital to be established in Greater Winnipeg, 1871, it was the last to establish a maternity department. For a time maternity patients were sent to Misericordia Hospital, where the St. Boniface student nurses got their obstetrical training. In 1916 a small maternity ward and delivery room were opened in the north wing of St. Boniface Hospital. The work gradually expanded. In 1920 maternity cases admitted numbered 223. In 1921 a new maternity department, St. Anne's Ward, was opened with 13 beds and two case rooms. In 1924 there were 433 maternity cases; in 1932, 1,081; and in 1941, 1,649. In December, 1942, a complete new department was organized on the fourth floor of the hospital. It consists of 66 beds with three delivery rooms and two nurseries. In the year just ended (1945) 1,966 babies were born in St. Boniface Hospital.

#### Present Distribution of Maternity Beds

Maternity beds in Greater Winnipeg hospitals number 282, distributed as follows:

Winnipeg General	52	St. Joseph's	14
Misericordia	37	Concordia	14
Grace	76	St. Boniface	66
Victoria	23		

#### Change in Social Customs

At the present time accommodation in the maternity hospitals of Greater Winnipeg is strained to the limit. To some extent this reflects the growth of the community in population, but to a much larger extent it is accounted for by a change in social customs. When the maternity hospital was built, midwifery in the home was the established custom and only the exceptional patient went to a hospital to be delivered. Year by year, however, more and more patients entered maternity hospitals, and the number of home deliveries declined.

This change is shown in the following figures, which have been supplied by the City Health Department:

#### Percentage of Live Births in Winnipeg Hospitals and Maternity Homes

1912	31.5%	1930	82.5%
1917	36.3%	1935	92.0%
1922	53.3%	1940	97.1%
1926	70.9%	1945	98.7%

#### Attendant at Births in Winnipeg (including Non-Residents)

Year	Midwives	Physicians
*1917	1,005 (18%)	4,633 (82%)
*1920	699 (11%)	5,716 (89%)
1925	250 (5%)	4,379 (95%)
1930	83 (2%)	4,558 (98%)
1935	16 (0.4%)	3,774 (99.6%)
1945	6 (0.1%)	5,650 (99.9%)

\* Includes stillbirths.

#### Improvement in Maternal Mortality

The claim has been made that it is safer for women to be delivered in their own homes than in maternity hospitals. This is not borne out by the following statistical table supplied by the City Health Department:

#### Maternal Mortality in Winnipeg 1911-1945 Non-Residents Included

Period	Live Births	Puerperal Deaths	Rate per 1,000 Live Births
1911-15	26,528	174	6.6
1916-20	28,475	194	6.8
1921-25	26,266	123	4.7
1926-30	22,542	122	5.4
1931-35	19,878	94	4.7
1936-40	19,021	80	4.2
1941-45	26,346	52	2.0

#### Winnipeg Residents Only

1931-35	15,690	67	4.3
1936-40	14,202	57	2.0
1941-45	20,026	42	2.1

It is a far cry from 1883 with its maternity hospital of 17 beds in an old house directed by a group of earnest women to 1946 with seven maternity hospitals providing 282 beds and staffed with professional nurses. With the prospect of a new separate maternity pavilion with up-to-the-minute equipment, including a blood bank, it is reasonable to suppose that there may be set up even better records in the saving of lives of mothers and babies. No effort is too great to secure such an aim.

My thanks are due to Dr. W. E. Campbell, who put me on the track of the first caesarean section in Winnipeg; to Drs. A. W. Moody, S. J. Elkin.



George Camsell and James Pullar, who gave additional information; to Dr. F. D. McKenty, to Miss Timlick and the Record Room staff of the Winnipeg General Hospital, who were untiring in looking up records; to the Sisters of St. Boniface,

Misericordia and St. Joseph's, and to the heads of Grace and Concordia Hospitals. I am especially grateful to Mr. A. G. Lawrence, secretary of the City Health Department, who prepared and furnished the statistical tables.

## Section of Anaesthesiology

P. C. Lund, M.D., Anesthetist, Deer Lodge Hospital

### First Anaesthetists Meeting a Success

The first annual meeting of the members in Western Canada of the Canadian Anaesthetists Society, held in Winnipeg on March 15th and 16th, was a huge success. Fifteen members from Winnipeg and sixteen others from Manitoba, Saskatchewan and Alberta attended, as well as some of the graduate internes in the Winnipeg hospitals. Clinical demonstrations were given at the Winnipeg General, St. Boniface and Deer Lodge hospitals in the mornings.

On March 15th the members were luncheon guests at the Winnipeg General Hospital, following which Dr. Ralph Knight, of Minneapolis, the guest speaker of the meeting, gave an interesting paper on anaesthetic agents and technique. Dr. Harold Rice, Associate Professor of Physiology, read a very instructive paper on "Carotid Sinus and Carotid Body," including some of his own work in this field. Following were two round table discussions on spinal anaesthesia and ether, led respectively by Dr. Harold Hutchinson and Dr. C. Neilson. These sessions both brought out many good points and gave everyone an opportunity to voice their opinions.

In the evening the Winnipeg Medical Society had graciously invited us, a section of the Society, to take charge of the regular monthly meeting. Dr. Ralph Knight spoke on "Anaesthesiology of the Future," and of the wonderful opportunities available for the young graduate in this, the last frontier specialty of medicine. Dr. P. H. T. Thorlakson, speaking on the surgeon and anaesthetist relationship, gave a short resume of the history of anaesthesia and its personnel in Winnipeg, and the necessity for the various members of a surgical team to co-operate with one another pre- and post-operatively, as well as during the actual operation, if we hope to get the most favorable outcome.

Dr. Ralph Knight was the after-lunch speaker on the following day, at the St. Boniface Hospital. He chose "Combined Pentothal Anaesthesia" for his subject on this occasion, giving some of his personal experiences, and also demonstrated some anaesthetic gadgets of his own making.

Dr. Bruce Chown read a paper on the Rh factor, leading us through its many intricacies, and gave examples with case histories. Dr.

Beverley Leech, of Regina, very ably lead a discussion on the all-important subject, "Economics of Anaesthesiology."

The scientific sessions were brought to a close with a round table discussion of cyclopropane and curare, led by Dr. Marjorie Bennett.

The Ladies' Committee arranged a luncheon at the Ralph Connor House for the wives of the local and visiting members on the 15th, and in the evening they held a theatre party, following which coffee was served at Mrs. D. C. Aikenhead's home.

The two-day meeting was brought to a close with dinner at the Fort Garry Hotel, where places were set for 51, and the party then attended the delightful Winnipeg Ice Carnival.

The meeting next year is to be held in Edmonton.

### Winnipeg Anaesthetists Society

The regular monthly meeting was held in the Coffee Room of the Winnipeg General Hospital on Monday, April 1st. After the necessary business was transacted, records and the keeping of records for statistical purposes was discussed. Dr. Revell presented the Nosworthy card which had been in use by the Armed Forces overseas. A committee of Drs. Rumball, Bennett, Revell, Hutchinson and Brenner was struck for further investigation into other methods and to report at the next meeting. Dr. Aikenhead suggested that if we found a form suitable to us it might be presented at the Annual Meeting of the C.M.A. in Banff, with the hope that some form might be officially adopted by the Canadian Anaesthetists Society.

### Abstract

#### Low Spinal Anesthesia in Obstetrics at the Indianapolis City Hospital

Salb, R. L., and Mueller, L., *Anest. and Analg.*, 2: 84-87, 1946

Spinal Anesthesia in Obstetrics was employed in 1885 and later in 1900, but was abandoned because of the undesirable after-effects and side reactions of cocaine which was at that time the spinal anesthetic agent of choice. Klein in a recent article reports excellent results in 322 deliveries carried out under low spinal anesthesia.

A series of 250 cases is reported in which 50 mgs. of procaine injected in the usual manner was employed in each case. In the majority of cases the patient ceased to feel labor pains in about three to five minutes after the injection. There was no marked fall in blood pressure and no ephedrine or other analeptic was used. Uterine contractions continued while the patient was under the influence of the anesthetic; however, the patient lost all urge to bear down and to use accessory powers of labor. Most patients promptly fell asleep after being relieved of labor pains, but bearing down could be induced if the patients were asked to do so, though it was never with the same vigor as in the normal stage of labor.

The most opportune time for administering the anesthetic is after full dilatation of the cervix. About 70 to 90 minutes of anesthesia resulted which permitted sufficient time for preparing and draping the patient, applying forceps, and repairing after episiotomy. Anesthesia in most cases reached to about 5 cm. above the pubis, but in several cases it reached to the lower costal margin.

Duration of the third stage of labor was found to be about the same as if no anesthesia had been used. Average blood loss in the third stage of labor and immediately post-partum was found to be less than when ether anesthesia was used.

Of the 250 cases delivered 206 were free of any pain after delivery. Eleven patients delivered were multiparas and the rest were primiparas. If any pain was felt during delivery it was usually upon traction on the forceps. If the patient complained supplemental anesthesia was given.

Two infants were still born. The one was a twin weighing  $3\frac{1}{2}$  lbs., and the other was in the R.O.P. position requiring a difficult manual rotation.

Manual removal of the placenta, required in three cases, was more difficult under spinal anesthesia than under ether anesthesia because of the lack of relaxation of the uterine musculature.

Nine cases of persistent posterior positions were delivered as such. There were two tears into the rectal sphincter which were easily repaired due to the excellent relaxation and the results were good. Two Scanzoni rotations of the fetal head were done and in two cases the head was rotated manually. In general, rotation maneuvers were more difficult under spinal anesthesia because of lack of relaxation of the uterus.

On four patients mid-forceps application and delivery was done because of persistent transverse position of the fetal head after full dilatation of the cervix.

Most patients in this series who received a spinal anesthetic never knew nor remembered that they had received a lumbar puncture. The

incidence of urinary retention was no greater among these patients than among those who received ether anesthesia. Headache was seldom complained of and never required a narcotic for its relief. After pains were no more severe than after ether anesthesia, or after no anesthesia. After pains were certainly not complained of as bitterly as when caudal anesthesia was given.

There are many advantages of spinal anesthesia. The blood loss is probably less than in delivery without anesthesia. The perineum and vagina are relaxed, making application of forceps simpler than under ether anesthesia. Relaxation of the vagina, and to some extent the cervix, made for less molding and trauma to the fetal head. The baby was in no way narcotized under spinal anesthesia and usually breathed spontaneously before delivery of the umbilicus.

Any patient with an acute respiratory infection, asthma, emphysema, or pulmonary tuberculosis reacts better under spinal anesthesia than under inhalation or local anesthesia because the bearing down effort involving the diaphragm is eliminated. Also pneumonia and lung abscess are no longer a hazard. This is especially true when the woman must be delivered after a meal, as in precipitate labors.

Eclampsics, pre-eclampsics, and nephritics are more safely delivered under spinal anesthesia. The patient's general metabolism is less disturbed by this form of anesthesia. Since there is little or no change in blood pressure the urinary output is not altered and dehydration is not produced by vomiting or by withholding of oral fluids. Likewise, exophthalmic goiter patients and diabetics will be disturbed less under spinal anesthesia.

It is also the safest and most useful method of delaying labor without injury to the mother or baby. Seldom will the baby be delivered without the voluntary aid of the mother and under spinal anesthesia she is able to bear down or relax at will.

Spinal anesthesia is technically much simpler to perform than caudal anesthesia, the incidence of failure much lower and the danger of infection far less.

The disadvantages of spinal anesthesia are chiefly the lack of relaxation of the uterine musculature in attempting an intra-uterine operative maneuver. And to a lesser extent, the desire of some patients to be unconscious during delivery.

P. C. Lund, M.D.

#### New Concepts of Morphine Analgesia

Slaughter, D., *Anesthesiology*, 5: 508-516, 1944

After extensive animal and human investigation the author arrived at the following conclusions:

(1) The combination of prostigmine with morphine prevents the occurrence of the constipating effects noted when morphine is given alone.

(2) The combination of 8 mg. of morphine plus prostigmine 0.5 mg. has a greater effect in raising the pain threshold than has 16 mg. of morphine alone; also the rise in the pain threshold is more rapid.

A modified Hardy-Wolff-Goodell pain threshold

apparatus was used in making the above determinations.

Not only does the prostigmine enhance the analgesic effects of the small dose of the opiate to a point where it was nearly equivalent to the large dose of the opiate alone, but it also decreased the side reactions as observed when the large dose of the opiate was given by itself.

P. C. Lund, M.D.

## Clinical Luncheon Reports

### St. Boniface Hospital

#### Ankylosing (Rheumatoid) Spondylitis

Henry Funk, M.D.

(Dr. Funk presented four cases of ankylosing spondylitis. Two were fairly early cases and these were definitely improved by X-ray treatment. One patient was wearing a cast because of deformity, and the fourth, who had a completely rigid spine, had been almost completely relieved of intercostal pain.)

While "ankylosing spondylitis" is the term commonly used rheumatoid spondylitis is more correct because ankylosis does not invariably occur. Other synonyms are Marie-Strumpell Disease, poker spine, and spondylitis of adolescence. The condition usually begins during adolescence but may not appear until later. Usually it progresses to complete ankylosis and this may occur quickly, intermittently or slowly. Chief symptoms are painful stiff back, loss of weight, and fatigue. There may be localised areas of pain in the sacro-iliac regions or there may be radiation along the intercostal nerves.

Examination usually reveals a run down patient with varying degrees of spine deformity. Chest expansion is diminished and may be completely absent. Spinal movements are restricted and ultimately the spine tends to become completely rigid. The X-ray picture is characteristic. At first there is fuzziness of the sacro iliac articulations. Later a zone of atrophy appears with ultimate sclerosis and fusion of the edges. The spinal ligaments undergo calcification and ossification, which, together with the loss of density in the vertebral bodies, gives the spine a typical "bamboo pole" appearance. The triad, stiff sore back, limited chest expansion and X-ray changes in the sacro iliac articulations is almost pathognomonic of rheumatoid spondylitis.

Treatment consists of a combination of X-ray therapy and orthopedic measures. In early stages the spinal rigidity may be due to muscle spasm and proper postural rest in bed may abolish most of this. X-ray therapy consists of daily exposure (for 10 or 11 days) to a low voltage, wide dispersal

dosage 100 units. During this time the patient's posture is gradually corrected by placing him on a rigid mattress with increasing elevation of the thoraco-lumbar region by means of a pillow under the mattress, or the patient may be placed on a gatch frame in the reversed position so that the break intended for the knees fits under the thoraco-lumbar region. Later hyperextension exercises are instituted. When such measures fail and deformity exists, corrective hyperextension plaster-body casts are applied.

#### Dermatomyositis — Dr. J. C. Hossack

A previously healthy farmer of 48 took sick in April, 1944, with burning pain and weakness in his feet. Because of the duration of his illness he could not give a completely satisfactory history but the following appears to be reasonably accurate. The pain began in the feet and spread to his legs, which became swollen and red. At the same time there was increasing weakness which reached its height in the summer when he was almost powerless and had difficulty with speaking, swallowing and even breathing. After this he improved somewhat but his legs became shrunken and remained very weak. His feet were useless. In April, 1945, the weakness appeared in the left arm and, some weeks later, in the right. There was less pain and swelling in the arms than there had been in the legs. The weakness gave place to stiffness of the fingers which gradually became immovably flexed. Since then there has been a gain in strength but because of contractures the limbs are useless.

He lies with all his limbs flexed. The face is thin but otherwise normal. The arms are wasted and the fingers strongly flexed into the palms. The whole skin is somewhat dark but pigmentation is definite over the hands. The skin is glossy and firm. It does not glide easily over the muscles and cannot be picked up as is usual in cases of emaciation. The muscles are small, very firm, and feel like sand-bags. Power is remarkably good at the shoulders and even at the elbows but there is a regular limitation when a certain point is reached, just as if an inelastic check came

suddenly into action. The tendon jerks are barely present. Sensation of both kinds is scarcely affected.

The viscera of the chest and abdomen are apparently normal. His legs are wasted and weak with the feet dropped and completely powerless. At the hip and knee there is a degree of power but the same limitation of movement is observed as in the arms. The reflexes are absent but sensation is not grossly impaired. The skin feels firm and has, as it were, shrunken to fit the greatly wasted muscles. These have the same peculiar firmness that suggests bags filled with sand.

It is this peculiarity of the muscles which suggests the diagnosis. Arthritis, pellagra, polyneuritis, endocrinopathies, and scleroderma, as well as the neurogenic atrophies and the dysrophies can all be excluded. Of all the probabilities only myositis fibrosa remains as a possibility but these disorders are very similar.

Dermatomyositis is a rare disease which affects both sexes equally at any age and is due to an unknown infective agent. It produces first inflammatory and then fibrotic changes in the skin, subcutaneous tissues and muscles. The onset is insidious and usually lasts for a week or two before the classical signs appear. These are dermatitis, oedema and swelling of the muscles. The symptoms are fever, pain and weakness. The dermatitis is of various sorts—urticarial, erythematous, erysipelatosus. The oedema is chiefly present over the inflamed muscles and is non-pitting. The muscles first swell, become very painful and then shrink as a result of fibrosis. The flexors of the extremities are chiefly affected and fibrosis leads to contractures in the 50% of patients who survive. The fever is variable and usually is not great. Pain may be trivial or excruciating. It is most severe during the stage of muscle swelling and is aggravated by the dermatitis, and also by the oedema. Weakness and stiffness begin early and increase to extreme lassitude and contractures. Involvement of muscles concerned with swallowing and breathing places life in danger. Pneumonia is the usual cause of death. When recovery occurs the wasted muscles have unlooked for strength. The joints are unaffected. The nervous system appears to escape. Duration of life depends upon the condition in which the patient is left. There is no satisfactory treatment. The description of fibrous myositis differs from the above in the absence of fever, dermatitis, oedema and pain. If present at all the latter is slight. Both of these disorders appear to be allied to scleroderma and in all there may be an endocrine-autonomic mechanism which so far has neither been investigated nor explained.

### Clinical - Radiological Conference History

The patient, a female of thirty-five years of age, was first seen early in December, 1945, complaining of pain in the left upper abdomen and lower thorax; pain present for two years; general malaise for two years; and loss of appetite for about one year.

In the fall of 1943 she began to have pain below the left costal region radiating to the epigastrium. It occurred only about once or twice a month and was relieved temporarily by soda bicarb. No month passed without at least one attack.

In April, 1945, this pain became more severe and was gnawing in character. Loss of appetite became more apparent at this time. She found that the pain was relieved by taking milk or soup, but the soreness was not relieved. Sleep was not disturbed. She had a period of two or three weeks following this in which she was entirely free of symptoms, but they soon returned. Pain and soreness were partly relieved by food and she then spent a period in bed on a milk and egg diet. She felt quite well while in bed but the symptoms recurred when she returned to her usual routine. She still does her own housework but becomes tired more easily than before.

Both her parents, three sisters, and one brother, are alive and well. She has one living child and had one miscarriage at three months in 1942. She was ill in 1935 and a diagnosis of renal calculi was made. Condition was relieved by medicinal treatment. Physical examination was negative except for a palpable left kidney. There was no loss of weight, no nausea, no vomiting or shortness of breath, no melena or diarrhea.

### Gastric Analysis

Free HC<sup>+</sup> — 5; 11; 0; 18; 10; 16.  
Total acidity — 31; 45; 34; 55; 40; 33.  
Blood was 2 plus.

### Discussion

**Dr. H. M. Edmison:** Would you care to discuss this history, Dr. Pearlman, and do you think it contains sufficient information to venture a diagnosis?

**Dr. I. Pearlman:** No. One could not make a diagnosis from the information we have been given but there are a few points in the history that should be discussed. During the last year the patient has not lost any weight. Her pain was located in the lower left chest and left upper abdomen, radiating to the epigastrium. From this alone one's attention should be directed to the stomach first. This pain was definitely relieved by taking food or soda bicarb. and she placed herself on a milk and egg diet, all of which suggest



peptic ulcer. The location of the pain, that is, in the lower left chest and upper left abdomen, would suggest a gastric rather than a duodenal ulcer. The fact that gastric acidity was rather low is not an argument against gastric ulcer for we should remember that the average acidity in these cases is probably a little below that of normal people. In other words, most cases of gastric ulcer have a certain degree of hypoacidity.

The fact that the condition has been present for about two years without loss of weight, along with the presence of acid in the stomach, is very much against the diagnosis of a malignant lesion.

The palpable kidney must be mentioned. I think it is unlikely that this type of pain would be related to the kidney as one would expect a more severe pain in Dietl's crisis. There is still the possibility, too, of a chronic pain in this situation occurring at intervals being functional. However, there is sufficient reason to give the patient the benefit of the doubt and proceed with further investigation.

Examination of the stool for occult blood should certainly be done. It was stated that blood was present in the gastric analysis. Is this gross blood or just a streak of blood in the contents or is it occult blood? If it is gross blood it is probably of some significance, otherwise it would mean very little in a case of this kind.

Then I would ask for an X-ray examination of the stomach and duodenum in order to demonstrate or exclude a peptic ulcer. A gastric ulcer is not usually as painful as a duodenal ulcer and the pain is not so likely to be localized.

**Dr. Edmison:** Is there no point in the history to suggest that this patient might have a malignant lesion of the stomach?

**Dr. J. D. Adamson:** Was she free of symptoms at any time?

**Dr. Edmison:** During the first year it came only about once a month although no month went by without an attack.

**Dr. Adamson:** I would think there is a fairly good chance of her having a malignancy in the cardiac end of the stomach.

**Dr. Pearlman:** Would you think this from the history alone?

**Dr. Adamson:** No, I would think first of gastric ulcer, but histories are not infallible.

**Dr. Edmison:** During the period spent in bed on diet she was quite free of pain and there was no loss of weight. Of course, one of the most difficult areas to examine by X-ray is the cardiac end of the stomach and it is in this region that malignant lesions are most often overlooked. This patient did have a radiographic examination of the stomach and duodenum but the test for occult blood was not done.

There is a definite lesion of the greater curvature of the stomach involving almost all the middle third in the centre of which there is an area of ulceration. This was constant and there is no doubt that it is due to an organic lesion.

Many of the features of this lesion suggest that it is innocent especially the depth of the ulcer compared to the width. Malignant ulcers are usually comparatively flat with evidence of a thickened margin. On palpation this lesion did not have the hard induration one expects to find in malignancy. The four hour film shows the stomach to be empty except for a fleck of barium that remained in the crater. In spite of what I have said we were not prepared to say that malignancy had been excluded, especially because of the position of the lesion on the greater curvature. If this is innocent, then it must be the first one I have seen.

**Dr. A. T. Gowron:** From what I have heard of the history and the radiographic findings I would consider that this is an innocent lesion, but I would suggest that she be kept under close observation.

**Dr. Edmison:** Should she be placed on medical treatment during this period?

**Dr. Gowron:** Yes. She has apparently had this for two years and another month should make very little difference.

**Dr. C. E. Corrigan:** I think she is going to come to operation in any case. Even if this is innocent, and the chances are that it is not innocent, she will have to have an operation. That is a very large ulcer. However, I would agree to a month of treatment if the patient insisted. If operation were contemplated she would probably receive treatment for about a week anyway, and perhaps as long as three weeks. With a lesion of this kind there must be a lot of inflammatory change present and proper medical care with the patient in bed on a suitable diet would reduce the hazards of the operation. Two or three weeks of medical treatment is almost imperative for operation.

**Dr. Edmison:** This patient was placed on a period of treatment which lasted exactly one month. Re-examination of the stomach showed the induration to be considerably reduced and we were unable to demonstrate any ulcer crater. The ulcer may not have been completely healed but it was at least quite small. She had been free of symptoms almost from the day treatment was started. This had consisted of a restricted diet and Amphojel, rest, and a few other restrictions. Dr. McEwen, do you think that if this lesion had been viewed through a gastroscope that your opinion would have been influenced?

**Dr. D. S. McEwen:** That is impossible to say, not having viewed it. However, I think that more

positive information can be obtained regarding any particular lesion by gastroscopic examination than by either X-ray examination or operation, realizing, of course, that there are parts of the stomach which cannot be seen by this method. It may be that no one here has had that much experience but there are definite differences seen through a gastroscope which are not apparent by any other method of examination. This happens to be in a region which could be seen clearly and would have been a perfect case for gastroscopic examination.

**Dr. Edmison:** I agree that this patient should have been gastroscopied the first time she was seen, but for several reasons this was not done. At the time of the second examination medical opinion was that there was still a good chance of this being malignant, even though it had improved considerably. Will a malignant lesion with ulceration improve on ulcer treatment?

**Dr. Burrell:** I think that swelling and oedema may diminish so that the ulcer appears smaller.

**Dr. Edmison:** A third examination was done two or three days ago after an interval of about five weeks. At this time we were unable to demonstrate any lesion radiographically. Dr. Burrell, could you summarize this case briefly?

**Dr. R. O. Burrell:** I think that the most outstanding single factor in this case was the history which pointed to an innocent lesion. Next in importance, and some may not agree with this, would be the gastric acidity. These are two very significant factors in favor of a diagnosis of an innocent lesion. Then, most of the X-ray findings, except for the location, suggested that it was not malignant. The next two points of importance would be gastroscopic examination and operative findings but neither of these was done. Response to treatment is also of value and in this case it indicated an innocent lesion, but this requires a period of observation.

**Dr. Adamson:** Another differential point between ulcer and cancer is the test for occult blood. In ulcer, if you have serial tests over a period of time, occult blood will come and go. In the case of a malignant neoplasm the presence of occult blood remains constant.

**Dr. I. Pearlman:** Do we all agree that this is definitely an innocent lesion?

**Dr. Adamson:** I think so.

**Dr. Pearlman:** Could this, an innocent lesion, become malignant?

**Dr. Adamson:** No.

**Dr. Edmison:** What are the chances of this recurring?

**Dr. Burrell:** They are very good.

**Dr. Gowron:** If it does recur then she should certainly have an operation.

**Dr. Pearlman:** The chance of recurrence depends on whether the patient has learned how to live. She can greatly diminish the chance of recurrence by a proper way of living.

## Children's Hospital

### Swelling of the Knee Joint in a Child

Patient G. L., age 5 years 2 months, No. 454748; admitted December 21, 1945.

This boy had a slight limp in his left leg for two weeks before admission. He had complained of a little soreness in the left knee but the parents were not certain when swelling was first noticed. A hot water bottle and rubbing gave some relief, and up to December 20, the day before admission, he walked without much complaint. Then there was increased pain in the knee, definite swelling, increased limping and inability to stand on the left leg without support. There was no history of injury. His history was otherwise essentially negative.

Physical examination: Temp. 101° F., pulse 110, resp. 20. He did not look sick and, at rest, was in little discomfort. He kept his left knee slightly flexed. There was visible joint swelling without increase in local heat and with only slight tenderness. Passive joint movements were complete and with no marked pain. No other joints were swollen or tender and the remainder of the examination that was done was recorded as normal.

The course in hospital was marked by a rising temperature, reaching 103° F. on the fourth hospital day, then falling to an irregular fever ranging from normal to 101° F. The temperature was within normal limits by January 11. The pulse was consistent with the temperature. By December 26 there was definite increase in the joint effusion, but this subsided in a few days—a note December 31 stating that the effusion was no longer evident.

We have then a little boy, not acutely ill, with transitory swelling of one knee joint accompanied by moderate pain and fever. These signs and symptoms disappeared within 10 days of the time he was put to bed. He had no other treatment. This could not be an acute suppurative arthritis but an hydrarthrosis of what type? Rheumatic? Allergic? Specific infection? Traumatic? Careful physical examination of the eyes, the corners of the mouth, the teeth and the shin bones was not recorded. With later information available, the tibiae were found to be palpably and visibly thickened in the antero-posterior plane. The child had a syphilitic hydrarthrosis (Clutton's Joint). Complete physical examination is still of utmost importance in a correct clinical diagnosis.

It was actually the radiologist who made the diagnosis when he found thickening of the cortical bone over the shafts of both tibiae. The blood Wasserman was 3 plus; spinal fluid mastic negative, Wasserman 2 plus.

Clutton's joints may be unilateral or bilateral, tend to subside spontaneously without residua and may recur if not treated. Other stigmata of congenital syphilis are to be expected, though they may be limited, as in this boy, to tibial periostitis.

Treatment was instituted January 15 with a course of 1,625,000 units of penicillin over a 10 day period, in doses of 25,000 units every four hours intramuscularly.

At Ward Rounds January 31, Dr. A. R. Birt pointed out that the curative value of penicillin in syphilis is not yet certain. There is a delayed action on the blood Wasserman. It is proposed to follow this boy with re-checks of blood, and spinal fluid, in three to six months and subsequently for two years at least.

### St. Joseph's Hospital

#### Urachal Dermoid — Dr. R. Danziger

A healthy looking farmer of 35 complained of frequency and dysuria of three weeks' duration. He had had the same symptoms in a more severe form six weeks previously but medical treatment had caused them to subside. He had no other symptoms and examination was negative except for an abdominal mass which centered on the umbilicus and extended laterally for about four inches on either side and a little more than half that distance above and below. The mass was fairly hard, not tender, and freely movable in all directions, unless the abdominal muscles were tensed, when it became fixed. The tentative diagnosis was urachal tumor, and to confirm this special studies were made of the bowel and kidneys. The radiologist reported concerning the bowel: "There is no organic lesion of the gastro-intestinal tract. There is a dense shadow in mid-abdomen which shows areas of calcification and is about 15 by 7 cm. in size." Intravenous pyelograms were reported: "Both kidneys are reasonably well visualized and appear to be within normal limits." The urine contained many pus-, and a few red-, cells. The specific gravity was 1.017. The blood count was in every way normal.

On operation the mass was found to be enclosed in a thick capsule formed by the umbilical pre-vesical and vesical fasciae, and to lie between the fascia of the rectus and the peritoneum. In size it measured 8 by 4 by 2 inches. The omentum, transverse colon and small

bowel were adherent to the peritoneum which was also adherent to the back of the capsule. The pathologist reported the contents as being a "crumbly, cheesy, gritty material" which, on microscopic examination, was seen to be "of amorphous material, indicating a dermoid cyst. Lining cells cannot be distinguished." Recovery from operation was uneventful.

The uro-genital portion of the cloaca is divisible into three parts. The cranial part becomes converted into the urachus or middle umbilical ligament, the intermediate portion becomes the urinary bladder, and the caudal part, in the male, develops into the urethra. Normally the urachal canal becomes obliterated but occasionally this does not occur and then there is patency, complete or in part. According to Sawyer, all pathological conditions of the urachus have this as a congenital basis. Vaughan has classified the types of urachal patency as follows: (1) Where it is complete from umbilicus to bladder; (2) where it is limited to the umbilical end; (3) where it is confined to the vesical end; (4) when it occurs in the middle with both ends closed. Fistula formation occurs most often in types one and two although as a result of infection it may appear in the other types as well. It is the "blind" or fourth type which is the usual basis for cyst formation. Colston says that secretory activity of the lining membrane may commence at any age and that therefore cysts may develop at any age. Changes within the cyst determine its size which may be quite small or so large as to simulate pregnancy (most cases occur in women). In some cases there may be ulceration of the wall, perforation and peritonitis.

In addition to cystic change the urachus may be the site of tumor formation, with the growth arising from epithelium, muscle or connective tissue and the process being benign or malignant. In the latter case there is early involvement of the bladder. Large cysts or growths may cause much difficulty in diagnosis unless the history is helpful. Sometimes the mass simulates a full bladder; sometimes an ovarian cyst. True dermoids are rare and according to Rock arise "in a piece of attenuated scar which becomes buried in the deeper tissues of the umbilicus." These cysts are seldom very large and tend ultimately to break down and discharge. In this case a communication between the mass and the bladder could not be proved but frequently this is through a very tiny, valve-protected and often kinked channel, and no other cause could be found for the symptoms.

Because all the sick do not recover does not prove that there is no art of medicine.—Cicero.

## Winnipeg General Hospital

### Ovarian Cysts — Physiology and Pathology

Drs. J. D. McQueen and D. Nicholson

The ovary in the reproductive period that contains no "cysts" in its substance or on the surface, is abnormal. Ovarian function is controlled primarily by the pituitary, although there are other glandular interrelationships. The first of these pituitary hormones, Prolan A, is the Follicle Stimulating Hormone (F.S.H.). This hormone is responsible for the development of the Graafian Follicle, which in turn produces a hormone which prepares the endometrium for the imbedding of the ovum. Those follicles which don't extrude an ovum remain for a time on the surface of the ovary but eventually atrophy and disappear. The second pituitary hormone, Prolan B, is the Luteinizing Hormone (L.H.) and it is responsible for the development of the Corpus Luteum. The Corpus Luteum secretes Progesterone which fills the glands of the endometrium, and desensitizes the uterus. About twelve days after the extrusion of the ovum, if there is no fertilization, the arterioles deep to the endometrium go into prolonged spasm which leads to ischemic necrosis and shedding of that superficial part of the endometrium which is so devitalized.

Retention cysts due to the failure of the Corpus Luteum to rupture are hence the result of deranged physiology and cannot be considered pathological. They sometimes contain blood but are usually filled with serous fluid and are seldom larger than a tangerine orange. It is these cysts which are so often excised as surgical treatment for lower right-sided pain when the appendix is found to be normal. Such patients often show clinical evidence of hypothyroidism and it is possible that the Corpus Luteum fails to rupture because of insufficient thyroid stimulation. If this fact were appreciated there would be much less mutilation of ovarian tissue, which actually amounts to partial castration, and more effort would be made to determine the reason for the development of such a retention cyst. If the cysts are larger than a tangerine there is always the danger of torsion, but it is better merely to puncture them rather than perform an ovariectomy, or even an excision which leads to scar formation with contraction and atrophy of remaining ovarian tissue. No such retention follicles are ever discovered following the menopause, so they must all eventually become atretic, although it is not known how long this process takes. Similarly, though fortunately not so frequently, a Corpus Luteum of pregnancy is removed at operation with consequent abortion.

Dr. Nicholson showed a number of kodachromes of ovaries removed at autopsy in otherwise normal young women who met accidental death. One

from an eighteen-year-old had a large haemorrhagic retention cyst on the surface. Others had many such cysts of varying sizes, superficially and in their substance. He stressed the importance of nomenclature and suggested that such terms as "Polycystic Ovary" or "Cystic Disease of the Ovary" had been partly responsible for surgical treatment of this benign condition. He contrasted these physiological cysts with the "Cystomas" which are true cystic neoplasms of the ovary, and include the Serous and Pseudomucinous forms (benign and malignant) and dermoid cysts of the ovary. Such ovarian neoplasms differ markedly from any others in the body because the ovary contains totipotent cells. He pointed out that it is rare to receive a request for examination of a frozen section before removal of ovarian tissue, although the microscopic picture in the case of Cystomas is typical and there is never any room for argument, as there so often is regarding lymph nodes. He urged that if there is any doubt, such an examination should always be carried out before excision is performed.

#### Comment

Dr. F. G. McGuinness re-emphasized the fact that retention cysts are normal and that whenever they are found one should look for the cause and deal with it.

Dr. B. Best mentioned four reasons for the too frequent removal of normal ovaries:

1. The impression that lower quadrant pain is frequently ovarian. Actually this is so only in rare cases associated with torsion of the ovary or a complication of a neoplasm. The ovary is normally a tender organ and complaint of pain on deep palpation due to compression of the ovary is not an indication for excision. Many women who have lost both ovaries still have the pain that ovariectomy was designed to abolish.

2. Confusion due to ponderous nomenclature. Fewer ovaries might be sacrificed if retention cysts were referred to, as suggested by Dr. J. D. Adamson, as "Blisters of the Ovary."

3. Excision of cysts or ovaries is a relatively simple procedure, too easy for one afflicted with the "Furore Operativus."

4. Inadequate knowledge of ovarian physiology.

He spoke of six cases seen within the last two years in all of whom cysts at least the size of a tangerine could be felt at first examination, all of which had apparently disappeared in six months' time. He suggested monthly checks: often the cysts, which are thin walled, will rupture spontaneously during the examination, and most of them will be found to decrease in size month by month. If they persist after six months or increase in size the possibility of a Cystoma must be considered.



Dr. Bruce Chown closed the discussion with an aphorism: "A nodule in the breast is better out than in; a nodule in the ovary is better in than out."

#### Observations on Intussusception

Dr. H. Medovy

Intussusception is the commonest cause of intestinal obstruction in infancy. The onset is dramatic and the course, when promptly treated, usually uneventful. Certain difficulties in diagnosis, and deviations from the classical course were illustrated in a presentation of five recent cases:

1. A two-year-old male, quite well an hour before, suddenly developed vomiting and severe abdominal pain which caused him to double up. Two hours later when examined he appeared played out, lay quietly in bed, and offered no resistance. A mass was felt in the right abdomen. An enema produced a small return of stool and some bloody mucus. In hospital two hours later no mass could be made out, but a barium enema revealed some obstruction at the lower end of the caecum. This appears to have been an instance of auto-reduction which was completed by the pressure of the barium enema.

2. A one-year-old male child suddenly vomited, became pale and almost breathless, so that his mother feared he had died. When examined he was white-faced, quiet and apathetic, yet wore a worried expression. There was no resistance to palpation, and a mass was perceptible in the right abdomen. Two hours later in hospital, after a saline enema, no mass could be felt, and there was no blood on the examining finger when withdrawn from the rectum. Barium enema revealed an unreduced intussusception — which was dealt with surgically with no complications ensuing.

3. An eight-month male infant, one hour after its evening feeding, vomited, became pale and passed blood with stools. A mass was easily felt abdominally and blood followed the retreating finger after rectal examination. In hospital a short time later the child looked well, no mass could be felt, and the parents thought the child had quite recovered. Barium enema showed an intussusception which had passed around to the hepatic flexure, where it could not be palpated under the liver. Operative reduction was performed half an hour later, with uneventful recovery.

4. A three-year-old male had had severe cramps all afternoon, each time doubling up with the pain, yet when seen was playing happily. The child had not appeared listless and there had been no vomiting or bloody diarrhoea. Palpation of the abdomen revealed the merest suggestion of a mass, and that for only a second. Return from enema was normal stool with no sign of blood.

The following afternoon symptoms returned, again without vomiting, blood in stools or perceptible mass. Leukocytes were 9,000 per cu. mm. Enema produced normal stool. The next day pain recurred, the boy was more apathetic but no mass was felt. This time he was kept in hospital, the impression being that there was recurring pain from obstruction probably due to a congenital band. The following day, four days after the first complaint of pain, a barium enema revealed an intussusception, the head of which was under the liver. Surgical reduction was successful.

5. A seven-month-old female infant had been sick for 24 days, with periods of vomiting and colic and weight loss of 6 pounds. Repeated adjustment of formula had been to no avail. Further inquiry into the history brought forth the information that on the first day of illness the baby had cried a lot, pulled up its legs and passed several stools, with what the mother thought was a cupful of blood. Since then there had been only the recurrent colic, vomiting and weight loss. The child was tired and weak, and examination revealed a fullness in the upper abdomen, with crying on deep palpation. Barium enema was given and under the fluoroscope a chronic intussusception revealed. Surgical reduction was difficult, the operation taking over half an hour, but the post-operative course was uneventful.

This type of intussusception was first described by Still, who pointed out that usually the weight loss is the most prominent feature, the other signs and symptoms, and the type of onset being often lost sight of.

#### Comment

Dr. J. S. McInnes advised routine fluoroscopic examination, after barium enema, in all cases of intestinal obstruction in infancy and early childhood with a history at all suggestive of intussusception. He commented on the marked reduction in mortality in the past 25 years. At the Children's Hospital, in nine cases reported in 1921, mortality was over 50%. For 137 cases from that time till 1944, death rate was 18%. He felt that much credit was due to those who were "intussusception conscious," made the diagnosis and referred the case early for treatment.

Dr. Childe suggested that early barium enema is of value not only in establishing the diagnosis, but also in ruling out intussusception in such conditions as dysentery when the symptoms are suggestive.

#### Hyperparathyroidism With Renal Calculi

Drs. Thorlakson, C. B. Stewart and McGeachy

The patient is a 47-year-old woman who in January, 1946, came complaining of giddiness

without loss of consciousness, of one day's duration. Other symptoms were palpitation for three years, and nocturia x3 for a longer period. She was a small woman of 110 lbs., not in obvious physical distress but anxious. Positive physical findings were B.P. 160/90, mass in left abdomen (previously diagnosed hydrosalpinx and treated conservatively) and small cervical polyp. Urinalysis revealed specific gravity of less than 1.012, a faint trace of albumin, 6-8 r.b.c.'s and 15-20 w.b.c.'s. Haemoglobin was 77%; smear showed slight anisocytosis and polychromasia. It was felt that her symptoms were probably the result of a disturbed emotional state. Treatment was iron and phenobarbital.

There was no improvement in the blood picture with iron medication, urinary sp. gr. remained consistently low, and one day she brought a small stone she had recently passed. Resurvey of the history brought out the information that she had been passing small calculi for ten years, during which time she had periodic aches in the loin and abdomen but no severe pain. These facts had not been mentioned previously as she was under the impression that it was not unusual to pass "gravel."

At this time an intravenous pyelogram was done. There was no excretion from the right kidney, which had a calculus in its pelvis. There were many calcium shadows in the left kidney. Blood serum calcium levels were from 11.9 - 15 mgms. and inorganic phosphate 2.3 - 2.5 mgms. per 100 cc. Alkaline phosphatase levels were normal (less than 13 King units), acid phosphatase was 2.5 - 2.8 King units (normal 2.). X-ray of skull, right arm and left leg showed no evidence of bone demineralization or cyst formation.

Right upper ureterotomy was performed with removal of the calculus. A T-tube was left in for three weeks. At operation there was no urine in the kidney but post-operative daily excretion from that side was 1,000 - 1,500 cc.

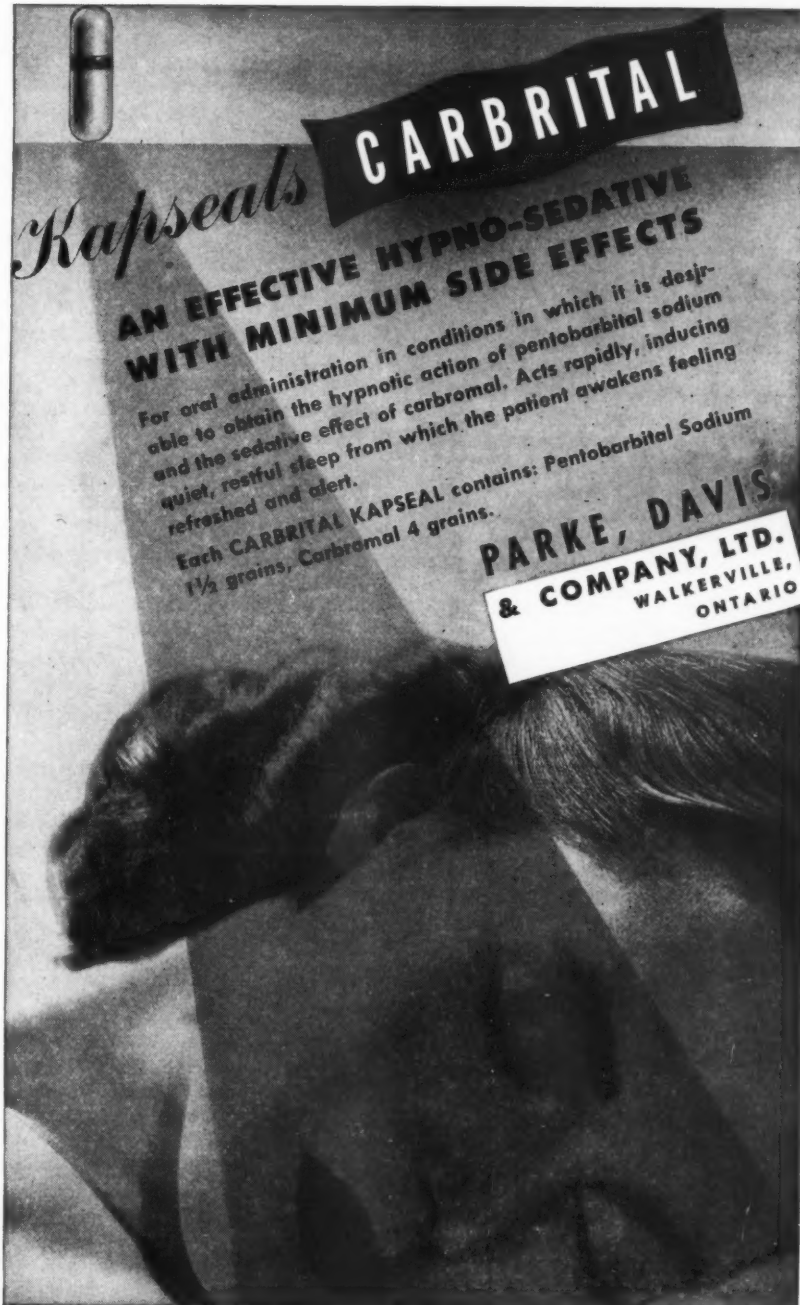
On March 23rd, surgical exploration for parathyroid adenomata was carried out, through a Kocher incision. The thyroid was thoroughly mobilized and behind it were found three adenomata which were removed. The superior mediastinum also was explored. Three days following operation blood serum calcium was normal. Haemoglobin has now risen from 80% to 90%. Blood pressure in hospital varied from 80/50 to 100/70. It is to be expected that there will be no recurrence of renal calculi and that many of the calcium deposits in the left kidney will disappear. It has been recently reported from the Mayo Clinic that 10% of calcium phosphate stones are associated with hyperthyroidism.

#### Comment by Prof. A. T. Cameron

1. Only with **primary** hyperparathyroidism are there changes in blood chemistry.
2. Blood serum calcium is normally from 10 - 11 mgm. per 100 cc. (extremes 9.5 - 11.5).
3. Occasionally with parathyroid adenomata the level may not go above 11 mgm. per 100 cc.
4. The function of the parathyroid hormone is believed to be the control of phosphate excretion through the kidney.
5. In hyperparathyroidism renal calculi may appear long before any bone changes are revealed by X-ray.
6. Usually following surgical removal of adenomata there is a rapid drop of serum calcium to 7 to 8 mgm. with the development of tetany. This case is unusual in that such a post-operative hypocalcemia did not develop.

W. G





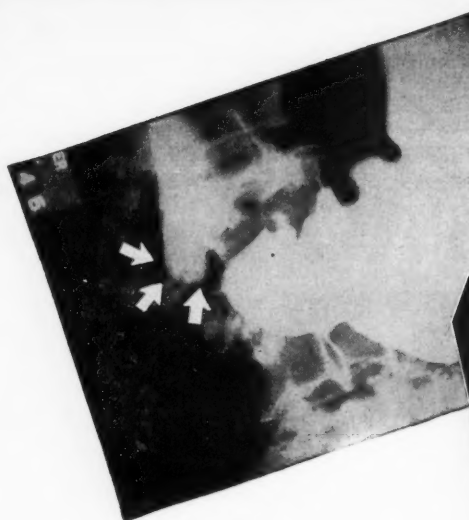
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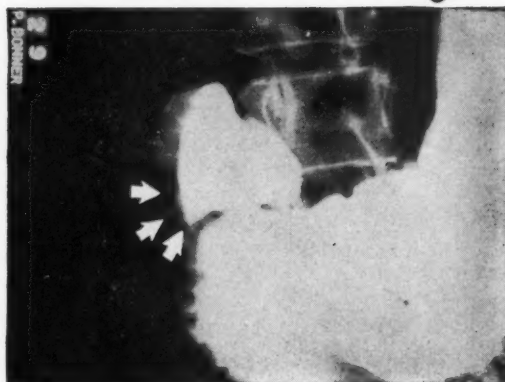


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**Next Meeting**

**May 17th**

C. K. Bleeks, *Treasurer*

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You are requested, on the 17th instant, to attend the Annual Meeting of your Society, to listen to the various reports, to express your wishes in the matter of choice of officers for next session and to hear the President's address. This last meeting is not the least important of the year. Then you can learn of the labors of your colleagues, all of whom, keenly alive to the honour and responsibility of their offices, have placed your interests and your affairs before their own convenience or profit. Dr. Goodwin has chosen as his topic "The History of the Medical College." This is an important subject at a time when the future of our alma mater should be for all of us a matter of concerned interest. But Dr. Goodwin does not mean to discuss the future. He will inform or remind his hearers about past difficulties and triumphs, and furnish that inspiration for future endeavours which comes from the recitation of past achievements. Dr. Goodwin, by his faithfulness to his trust, has deserved well of you, and your attendance on his night is a pleasant way of showing your appreciation.

### William Heberden

Our date of meeting has on every occasion fallen upon some anniversary famous in medical annals. The 17th of May is doubly distinguished for upon that date (in 1749) was born Edward Jenner, and upon it (in 1801) died William Heberden. Upon it, too, (in 1163) died the unfortunate Heloise whose story is the sad tale of man's selfishness and woman's devotion.

The name of William Heberden is familiar to all physicians and students because it is attached to the nodes commonly found on arthritic fingers. Although it is to these that he chiefly owes the perpetuation of his memory he himself was not greatly interested in them. "What are these little hard knobs about the size of a pea which are frequently seen upon the fingers near the top near the joint?" They were not, he realized, gouty, but he did not pursue his enquiry. Less well known is the fact that he was the first to give an accurate account of angina pectoris, 20 cases of which formed the basis of a paper entitled "Some Account of a Disorder of the Breast" and delivered, in 1768, before the Royal College of Physicians.

Heberden was born in 1710 and studied at Cambridge, from which University he obtained the degree of M.D. in 1739. About that time (a

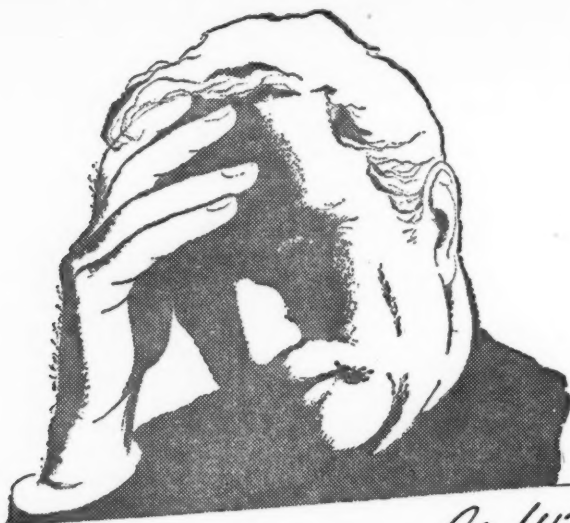
few years later) there was a change in the occupant of the Regius Chair of Physic. The then occupant, Christopher Green, had held the appointment for 41 years. His successor, Russell Plumptre, was destined to fill it for 53 years. These long tenures of office by men of small eminence did not further the cause of medicine at Cambridge. Had it been the fortune of Heberden to have been nominated in place of Plumptre it would have been fortunate for Cambridge also.

Heberden was a true disciple of Hippocrates and Sydenham, for he used his own eyes, studied his own observations and used his active mind as an organ of thought rather than of memory. He was especially interested in reforming and rationalizing the system of materia medica and therapeutics. He was the relentless enemy of the irrational, magical practice of many of his contemporaries. He purged the Pharmacopoeia of much dross, including the famous (or infamous) Theriac of Mithridates. On this particular question his colleagues of the College were so evenly divided that Heberden won his point by a single vote.

Heberden in his commentaries tells how these "were prepared from notes collected at the bedside and revised every month in a light of fresh cases, but without borrowing from other authors." There is much wisdom in his sayings and much which can be applied to ourselves. Here are some quotations: "Many physicians appear to be too strict in the rules of diet and regimen." "We have the misfortune to have innumerable remedies for the worm, this being pretty generally a sure sign that we have not one upon which we can with certainty rely." "Palpitation of the heart in many instances arises from causes too fatal to admit, or too frivolous to stand in need, of cure." "By attentively observing nature itself a greater progress has been made during the last century than had been till that time from the days of Aristotle." "It were to be wished that writers would not confine themselves to relate only their successful practice but would have the courage to tell us the ineffectual and hurtful."

Heberden did not marry until he was 50 and then had five sons and three daughters. One of his sons became Physician-in-Ordinary to King George III. Principal among his friends were Cowper and Dr. Sam. Johnson. It will be remem-

Continued on Page 294



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1. Spies, Tom D.; Cogswell, Robert C., and Vilter, Carl: J.A.M.A. (Nov. 18), 1944. Spies, Tom D.: Med. Clin. N. Am. 27:273, 1943.  
2. Spies, Tom D.: J.A.M.A. 122:911 (July 31) 1943. 3. Jolliffe, Norman, and Smith, James J.: Med. Clin. N. Am. 27:567 (March) 1943.

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## Editorial

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J. C. Hossack, M.D., C.M. (Man.), Editor

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### Salute to Nurses

This is the graduating season for nurses. The fruit which has for three years been ripening in hospitals all over the continent, now bears upon it the blush of maturity and is being ceremoniously removed from its parent plant. There are few more touching, more colourful or more delightful occasions. The long, sometimes tedious, and often hard journey has reached its end, but all past trials are forgotten in the present triumph. The white-clad maidens with rosy cheeks, sparkling eyes, and smiling faces sit embowered in armfuls of flowers enjoying the biggest moment, so far, in their lives. Not even the tediousness of the speakers can mar their pleasure chiefly because their thoughts are elsewhere and the speakers speak to all but them.

The graduation of nurses differs from other graduations just as nurses differ from all other graduates. Of all women they are the most useful, for to their natural abilities have been added the skill which comes from training and the experience which comes from practice. Where would we doctors be were it not for the nurses? They share our anxieties, they supplement our efforts, they win for us credit that is often rightfully theirs. They seem to be unconscious of fatigue. They seldom frown and when they do it is rarely because of their own annoyances. They get little praise and few thanks, yet in spite of all this they carry on with tempers unruffled, enduring silently what few men would endure and toiling as no man would toil.

A few years ago nurses were so many and patients so few that their plight was almost desperate. At that time I had occasion to prepare some comments on nurses. Much of what I then wrote is still applicable and so, as a tribute, if you like, to those now graduating I set it in print.

### About Women and Nursing

Woman is an incomprehensible creature, nor does the fact that she may be a nurse make her any less so. It is difficult for a mere man to understand why she should undertake to mow herself up for three years (of 351 days each) in order that she may, at the end of it, be able to earn about as much as a scrub lady. If she hankers after the financial independence of a scrub lady she does not have to spend three years learning how, and if she does invest all that time one would expect her to make more out of her investment. But there you are. She spends her three years and pays her dues and alumnae fees and

her car-fare and laundry and room and ends up running neck and neck with the scrub lady.

Now with this dismal view in sight one asks why does she do it? There are, of course, certain frivolous reasons, as for example the glamour of being a "Woman in White," or the belief that nursing is a good way to catch a doctor for a husband. This belief is fostered by the delusion that all doctors are rolling in wealth and are as nice to their wives as they are to their patients. Usually after a girl has had three years' experience with doctors, the thought of being a doctor's spouse nauseates her, and if she does marry a doctor it is probably to get even with the whole tribe by getting even with one of its members. These, of course, are frivolous arguments which must not be allowed to influence this serious inquiry into why nurses are as they are.

The fact of the matter is that women are largely dominated by their instincts and the most powerful of all is the maternal instinct. It was present in the first woman and so the first woman was the first nurse because nursing is but a form of the maternal instinct. Perhaps you may have seen pictures of the Cro-magnon people. They lived many, many thousands of years ago and were our very early ancestors. They look scarcely human but I am sure that when Mr. Cro-magnon had a tummy-ache Mrs. Cro-magnon compounded some brew that brought him to his feet. Women have been doing this sort of thing ever since. In childhood they practice on their dolls. Later on they treat their husbands and children. In old age they instruct and supervise others when they themselves can no longer practice. Even those women whom fate has cheated of husbands and offspring nurse the husbands and offspring of others or, failing that, find a dog or a cat or a canary to soothe and croon over. Thus from the cradle to the grave woman goes through life nursing and mothering.

And so a lot of young women enter schools of nursing because they are very sorry for sick people and so anxious to help them. For a long time sympathy and a desire to help were all that was needed in a nurse. But not now. Now the maiden aspiring to be a nurse must furnish herself with a mass of knowledge that not even a doctor needed a few years back. She must understand quadratic equations and the theorem of Pythagoras. She must know chemistry and physics and botany. She must have a smattering of half a dozen "ologies." Just how these things are going to make her a better nurse we are not told. Fortunately most of this needless information is quickly forgotten to make room for other

facts scarcely more useful. The only really useful things one learns at school are how to read and write. Almost everything else is forgotten. If you don't believe this get someone to quiz you on subjects you used to know.

There must, however, be some standard and the standard chosen is book knowledge. I am afraid that a lot of people confound knowledge with wisdom. There could be no greater error. Anyone with a good memory can acquire large quantities of knowledge but wisdom is something you are born with—or without. It is the fashion nowadays to go in for knowledge. From the time a child is six years old knowledge of all kinds is crammed into him. He is kept so busy learning things that he has no time to reason out their why and wherefor. Periodically he is tested as to the amount of this information that he has swallowed. A mental emetic is administered in the form of an examination paper and the teacher anxiously watches to see how much he brings up. If he consistently delivers large quantities the teachers call him a bright lad, prophesy that he will "go far" and pin a medal on his proud chest. Then, to everyone's surprise, he turns out to be a complete flop, which is natural because all he had was a good memory.

The power to remember book-knowledge is a very poor criterion of a girl's ability to be a nurse. The important things that a nurse must possess are common sense (or in other words wisdom), and a pleasing personality. These are the heart and soul of nursing. Knowledge is merely the draperies that clothe it. A girl who has lots of common sense, a happy and pleasing manner and a modicum of knowledge is a good nurse. Without common sense and personality she is but a sounding-brass and a tinkling cymbal even though she has all knowledge and understands all mysteries.

And indeed it would almost seem that she is expected to have all knowledge and to understand all mysteries. It would appear that more and more hours are being spent in the lecture rooms and in classes. I believe that in some schools of nursing the pupils spend most of their time in lecture rooms and laboratories and learn nursing by watching others nurse. I do not know what fate has in store for me, but I sincerely hope that I don't fall into the clutches of such a nurse.

Nursing is a practical profession. The nurse's place is at the bedside. Her excursions to lecture rooms and laboratories should be few for there is nothing she can learn there that cannot be learned better at the bedside.

Lectures are an anachronism. They were useful centuries ago when books were few and costly and when, moreover, not everyone could read. Now books are easily come by. They can be read by the

student just as well as by the lecturer. Medical schools everywhere are reducing lectures to a minimum. Nursing schools appear to be increasing theirs. Nurses are also being given ward rounds just like medical students and, to even things up, medical students are being taught how to make beds and give enemas, just like nurses. If this keeps up much longer the doctors will be assigned the job of looking after their patients under the supervision of nurses, which might give the nurses a chance to get even with the doctors.

I have the idea that nurses could be taught about disease in a much simpler, more interesting and more helpful way. Let me illustrate. A nurse is looking after a patient with rheumatic heart disease and failure. At the bedside she notices the blueness, the breathlessness, the dropsy, the irregular pulse. Now let that girl be taken to the museum. Show her a normal heart. Let her see and feel the delicate valve leaflets. Point out the thickness of the muscle, the appearance of the valve rings and so on. Then show her the rheumatic heart with its deformed, distorted valves, its valve ring resolved to a mere slit or an almost bony funnel, its muscle thickened enormously in a desperate effort to drive the blood onwards. Tell her that what she sees before her exists in the chest of her patient. Such an experience will tell a girl more than a dozen lectures—and she will remember it. On the ward again she can be told how the various remedies act, the signs of an overdosage and so on. To cap it all she will understand what she reads when she turns to her book.

I have another idea—it is this. Seeing that nursing is a practical thing, why not make training a sort of apprenticeship with the supervisor acting as preceptor, the supervisor's job being not to see that the pupil conforms to the rules but that she learns her work. I imagine that the most valuable instruction the pupil nurse gets is from competent ward nurses and not in lecture rooms. A woman with common sense, experience, knowledge and a desire to help will teach a nurse more and better than the whole faculty of doctors. Perhaps I have given you the impression that I haven't much use for lectures. Neither have I. Taking it by and large, the pupils would be much better off if they did their sleeping honestly in bed instead of catching broken snoozes during a lecture. After a long, hard day on the wards it isn't reasonable to expect receptive minds.

But lectures, be they few or many, should not be allowed to encroach on the free time of the student. That, goodness knows, is little enough. Eleven hours is a long day and seven days is just as long as a week can be. There are some schools with the eight hour day but there are many more



which regard eight hours on the ward as an eight hour day but by lectures, classes, etc., take up ten or eleven hours. An eight hour day is one in which the nurse is free for the remaining sixteen hours.

Eleven hours a day and seven days a week make a seventy-seven hour week. The girl who sells hankies in Eaton's manages to get her week's work done in forty-four hours. She does her light work in an air-conditioned atmosphere and has an hour at noon to get a breath of fresh air if she wants it. But the nurse spends her day in the vitiated, contaminated atmosphere of sick rooms. Her work is heavy and her responsibility serious for in her hands lie life and death. If an eight hour day is long enough for the hanky seller, why should it be too short for a nurse? The principal argument used against the eight hour day is that it would mean each patient would have to become accustomed to three nurses. As it is, a lot of patients do have three nurses and all private patients with "specials" have to have three nurses. The fact is, there is no valid argument against the eight hour day.

And there certainly is no argument against a six day week. You see, if the nurse were as well off as the hanky seller she would not only get Saturday afternoon but all day Sunday and all the public holidays. That, with two weeks holiday, would give her 109 free days, more than three months out of the twelve. To the pupil nurse "holiday" and "Sunday" are words in the dictionary. Lucky hanky-seller! The law (not a bit romantic, not a bit interested in "Women in White") has eyes only for her and none for the nurse. The law says to the hanky-seller, "Poor girl, you mustn't work too hard; in fact, you must not work more than forty-four hours a week," but somehow the nurse's seventy to seventy-seven hours seems all right. No wonder Mr. Bumble exclaimed "The Law is a hass."

I cannot understand the seven day week. That divine ordinance which commands "Six days shalt thou labor and do all thy work" admits of no exceptions but even specifically includes the beasts of burden. Why, of all people, should nurses alone be denied that which even the animals can claim? What possible argument can there be against their enjoying that day of salutary rest which all mankind are not only counselled but commanded to observe, both by the laws of man and by the laws of God?

I wrote at the beginning of this article that woman is an incomprehensible creature. And so she is. How else can you explain her diligence in learning the rules of health and the theory of hygiene, and her failure to put her precepts into practice? Or, more properly, why is it that

she is given such instruction and deprived of the opportunity to apply it? Shop girls and factory workers who are ignorant of all things medical live healthier lives and practice better hygiene than do these young women, who spend their time learning all about disease and how to cure it, who are surrounded all day by health specialists but who at the same time live the most unhealthy lives of all. The people who need the most fresh air, the most sunshine, the most frequent spells of relaxation get the least of these. If shorter weeks mean a longer course it would be worth while, for it is better to reach the end of the journey strong and well than to crawl to it feeling numb and half alive, low in haemoglobin, low in blood pressure, low in spirits and low in health.

Nursing has advanced far along many fronts. The next advance (long overdue) must be in the conditions under which nurses train. The entrance requirements are high enough. The academic training is more than sufficient. But the old medieval practice persists in the tediously long hours and the complete week which, in this day and generation, are more out of date than the periwig and the bustle. Incomprehensible woman! In the forefront of every social advance, leading in every movement that aims at making life healthier and happier for mankind, and yet doing nothing (or at least nothing effective) to improve the outmoded conditions under which the cream of her sex are trained for their invaluable tasks!

J. C. Hossack

## Obituary

Dr. W. H. Clark

Dr. W. H. Clark died at his home in Portage la Prairie on March 24, after a long illness. Born in London, Ont., 69 years ago, he graduated in Medicine from Western University, London, in 1902. In the following year he came to Winnipeg and served as an interne in the Winnipeg General Hospital. For ten years he practised at Oakville, Man., then moved to Portage la Prairie in 1913, where he practised until his death.

Outside his practice he was active in the Methodist and later the United Church, and in fraternal societies. He was keenly interested in curling. For a time he was a member of the Executive Committee of the Manitoba Medical Association.

He is survived by his wife and two sons, one of whom is Dr. Cecil Clark of Winnipeg, until recently Lt.-Col. Clark of No. 5 Canadian General Hospital, R.C.A.M.C. Overseas.

## Addenda to Constitution and Bylaws

At the Annual Meeting of the M.M.A. in September, 1945, the following two resolutions were passed:

### Resolution No. 10

"RESOLVED that the President of the Manitoba Division of the Canadian Medical Association be the representative of the Canadian Medical Association Executive, and that the Vice-President be the alternate representative."

### Resolution No. 11

"WHEREAS it would appear advisable and necessary that there be the closest possible relationship between the Faculty of Medicine and organized Medicine as represented by the Manitoba Medical Association,

"BE IT RESOLVED that the Constitution of the Manitoba Medical Association be amended in such a way as to provide representation of the Faculty of Medicine, University of Manitoba, on the Executive of the Association, such representation to consist of one representative designated annually from its membership by the Faculty Council Executive of the Faculty of Medicine."

These resolutions mean a change in our Constitution and Bylaws. When these resolutions were sent to the Committee on Constitution and Bylaws they pointed out to us, insofar as Resolution No. 10 is concerned, that we do not elect a representative to the Executive of the C.M.A., we simply nominate him. At a subsequent meeting of the M.M.A. Executive a resolution was passed stating that we, the Executive of the M.M.A., interpret the word "representative" to mean "nomination." In the light of these events, it has been considered unnecessary to include the above Resolution No. 10 in the new Constitution and Bylaws, but this Resolution has already been passed by the General Meeting and so will have to be amended at our next General Meeting.

Regarding Resolution No. 11, the Committee felt that it was unnecessary to change the Constitution because in our present Constitution, Article 6, Section (a), gives the Association power to add a representative from the Medical Faculty as being an approved association that is autonomous and provincial in scope. This Resolution has been passed by the General Meeting and the change added to the Constitution and Bylaws, as above, but the same end can be gained by having this change amended by the General Meeting in September, 1946.

Changes in our Constitution and By-laws are so printed that they may be inserted in the blank pages of your book on Constitution and By-laws.

## Letter to the Editor

307 Waterloo Street, Winnipeg.

The Editor, 12th April, 1946.  
Manitoba Medical Review.  
Dear John:

An appraisal of the a/m publication under your editorship, compared with its predecessors of some 6 years ago, reveals a most sturdy and commendable evolution. It is indeed a journal of which all Manitoba doctors have every reason to be proud. (So much for the sugar coating.)

It is admitted that on occasion the odd typographical error may materialize under the eye of the most scrupulous proof reader. (Obviously working up to something.)

But when, in 2 consecutive issues, (here it comes) I note the employment of a misspelled, in fact, misnamed clinical entity, I feel I must rise in horror to indicate my disapproval. In both the March and April issues you run articles which refer to a disorder described as Osteochondritis DESSICANS. My comments are as follows:

- (a) there is no such disorder,
- (b) there is an osteochondritis DISSECANS,
- (c) the qualifying adjective is descriptively employed to indicate a DISSECTED appearance of the fragment, rather than a DRIED appearance,
- (d) you can verify this by consulting any recently published medical dictionary,
- (e) the use of the term DESSICANS is a common error,
- (f) Foreigners, whose only contact with our local profession is through your journal will be not unnaturally (i) irritated (ii) amused (iii) disgusted by (a) the sloppy proofreading (b) the implied professional ignorance (c) our apathetic attitude, and will so be left with a false impression of our worth.

So please, John, please, in future rearrange your vowels. You may have an opportunity to do so when you compile the next index.

With sincere best wishes and nothing less,

(signed) C. E. Corrigan.

## Notice Board

Continued from Page 289

bered that it was to him that Johnson penned, with his still-spared hand, the note telling of his aphasia. To Johnson, Heberden was "the last of the Romans." Heberden himself outlived his illustrious patient by many years, dying in his 91st year with his eye undimmed, his mind alert, his memory acute, his physical powers scarcely abated. Those who wish to amplify the information given in this sketch are referred to Sir Walter Langdon Brown's presidential address published in the Proceedings of the Royal Society of Medicine, Volume 37.

J. C. H.

The following is the list of candidates submitted by the Nominating Committee:

President	Dr. Walter F. Tisdale
	Dr. K. C. McGibbon
Vice-President	Dr. Cecil W. Clark
	Dr. T. E. Holland
Secretary	Dr. R. A. Macpherson
	Dr. W. George Brock
Treasurer	Dr. C. K. Bleeks
	Dr. Ross H. Cooper
Trustee	Dr. W. F. Abbott
	Dr. C. R. Rice



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## Medical Economics

The Economics Committee of the Manitoba Medical Association has been active since the last general meeting of the Association and the following is a report of the happenings in the different spheres of activities of your Chairman of Economics.

### Manitoba Medical Service

The resolutions passed at the last general meeting of the Association were conveyed by the Executive to the Board of Trustees of the Manitoba Medical Service. These resolutions requested the Board to institute the new Schedule of Fees which was passed at the meeting and to endeavor to make Plan B solvent.

The Fee Schedule Committee, of which Dr. F. D. McKenty is Chairman, Dr. Grant Beaton, Vice-Chairman, and your Chairman of Economics, the third member, is now studying this Schedule and will in due course of time arrive at a suitable revision and rewording which will be presented to the Executive of the M.M.A. for their ratification and transmission to the Board of Trustees of the Manitoba Medical Service. Until this is done the Manitoba Medical Service cannot apply the new Schedule.

Regarding the resolution which the M.M.A. sent to the M.M.S. requesting that Plan B be made solvent, action was taken by the Board of Trustees of the M.M.S. at their last annual meeting. They appointed a committee to study ways and means to accomplish this end and to bring in recommendations to the Board for implementation. I was appointed Chairman of this committee and in my committee were Dr. Grant Beaton, Dr. C. H. A. Walton, Dr. M. R. MacCharles, and Mr. E. Jones.

### Municipal Contracts

The negotiations for the final draft of the contract of a Municipal Doctor are proceeding. Your chairman was asked to negotiate for yearly increases in salary to the doctor amounting to \$2,000.00 through a period of time. I have succeeded in obtaining from the committee conducting the negotiations an increase of \$500.00 per year for four years—making the salary \$6,000.00 per annum after four years for those starting at \$4,000.00. I had to yield on another point in order to obtain the above, viz.: Doctors who have just graduated will start at \$3,600.00 per annum; one year after graduation they will receive \$3,800.00, and two years after graduation \$4,000.00; and from then on the same increment of increase of income, as mentioned above, will apply, i.e., an increase of \$500.00 per year until \$6,000.00 is reached.

The Health Commission is now studying the document upon which the bargaining committee have agreed and I feel that at the meeting next month the matter will be closed in a manner acceptable to us and in keeping with the propositions I outlined at the general meeting of the M.M.A. last March.

### Workmen's Compensation Board

In 1945 the Executive of the M.M.A. struck a committee to endeavor to revamp our arrangements and fees with the Workmen's Compensation Board. This committee consists of Dr. P. H. McNulty, Dr. F. D. McKenty, Dr. Henry Funk, Dr. W. I. Easton of Selkirk, Man., with your Chairman of Economics, as Chairman.

We have communicated with Mr. Cousley, the Commissioner of the W.C.B., and he has agreed to a meeting for the discussion and exploration of the questions. Your committee has met and is now preparing its case for presentation to the Commissioner. It is significant that the hospitals of Winnipeg are now negotiating with the W.C.B. for a new schedule of rates for their hospitalization.

Your committee is gathering into brief form all the definite arrangements which the M.M.A. has officially entered into with the W.C.B. and we are going to endeavor to obtain from the Board all rulings and decisions which have not been agreed to but which, by decision of the old Board of Referees or by unilateral action on the part of the Board, have come to be accepted by the W.C.B. and tacitly accepted by the profession so far without protest. With this basis we shall then be able to negotiate in an enlightened manner.

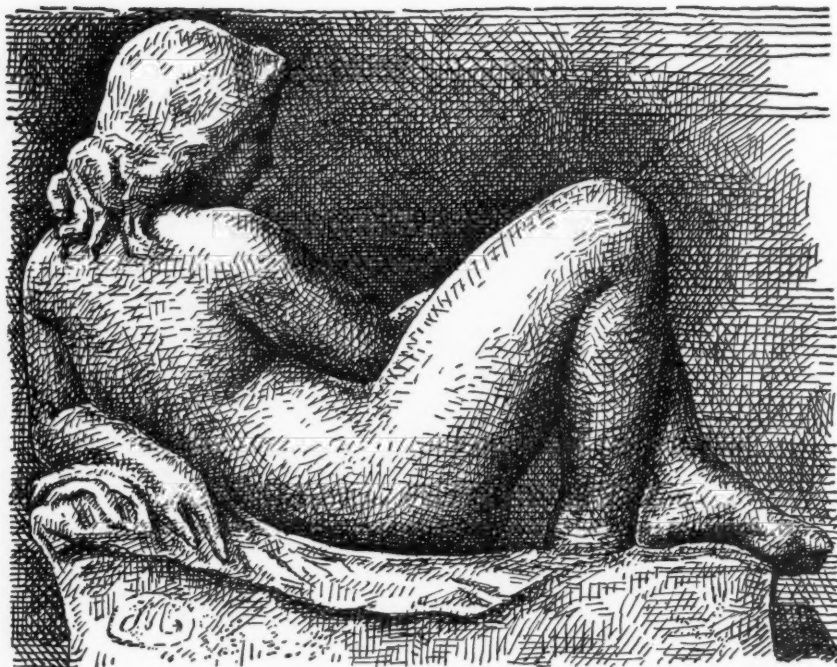
A. Hollenberg, M.A.

◆  
In pneumonia the disease is in the lungs but the danger is in the heart.—Lindsay.

### Full-Time Secretary Required

The Manitoba Division of the Canadian Medical Association invites applications for the position of a full-time secretary. Applicants must be graduates in Medicine from a recognized Medical School. Please apply to the Honorary Secretary of the Manitoba Medical Association, 510 Medical Arts Building, Winnipeg, stating age, school of graduation and date, service in the Armed Forces, executive experience and salary expected; also enclose a recent photograph.

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## Background of Relations with Workmen's Compensation Board

(Reprinted at the Request of the Compensation Board Committee)

### Explanatory

History continues to repeat itself: the reports from the minutes of the Manitoba Medical Association from 1924 to 1934 that are reprinted below show that some recently recurring friction between medical practitioners and the Workmen's Compensation Board reproduces exactly the troubles of twenty years ago, and that the causes are the same.

At that time a spirit of co-operation and the institution of the Referee Board succeeded in producing a satisfactory harmony which lasted as long as the original arrangement was remembered and followed.

Consideration of the subjoined reports of negotiations will indicate that the Manitoba Medical Association representatives followed throughout, as far as feasible, certain principles of policy which are fairly clear, although not explicitly stated in the reports. It may be useful to explain them more definitely as follows:

In the practical application of the art of medicine the main factors are all variable; none are fixed or definite. The patient, the disease, the treatment and professional skill are never twice the same. Continual adjustment and adaptation are inherent essentials for efficiency and rigidity and standardization are incompatible to the degree that they restrict adaptability. It is because of this that the effective administration of any large medical service scheme must always be a task of peculiar difficulty requiring the greatest degree of competence and flexibility.

The traditional free charity service of the medical profession does not apply to medical social service schemes under government. Such arrangements are instituted for the general welfare and the cost of them should be distributed equitably over the general population. No undue part should be carried by any one class. The returns to those rendering the service should be at the standards that have been reached in open competition, as with other occupations. To ask the medical practitioner to render service of a high standard for sub-standard returns, on the ground that the workman could not, in any event, pay for them, is not valid; the Workmen's Compensation Board was not instituted for the relief of the practitioner. It is inequitable because it forms a sort of hidden levy which imposes more than his proper share of the cost as a citizen.

The standard of service is ultimately closely related to the conditions of work and the returns. If the latter make the work second choice because of the competition of other more attractive fields

in medicine and a high standard of service is made more difficult to maintain, both the workmen and the medical profession have ground for dissatisfaction.

The terms of the Act and agreements between the Workmen's Compensation Board and the medical practitioner as to their interpretation and application, form the conditions upon which medical practitioners undertake to render service to the Board. Such conditions should not be changed except by mutual agreement between representatives of the respective bodies concerned.

It is a basic assumption that the majority of medical practitioners are honest and competent; the profession cannot rest under any arrangement or policy that implies the contrary; in the case of sub-standard individual members, the power of the College of Physicians and Surgeons is available to enforce restraint and discipline.

As indicated by quotations from officials of the Workmen's Compensation Board itself, the arrangements detailed below were tried and proven and functioned well for years. Some changes in details may now be needed to meet changed conditions, but the principles seemed to be sound. It would be rash to abandon them too readily.

### Report on the Present Relations With the Workmen's Compensation Board (1925-1934)

"The Executive of the Manitoba Medical Association have issued instructions that there should be prepared and published in this Review a clear statement of the present relations between the medical profession and the Workmen's Compensation Board of this province. The purpose of this statement is to facilitate co-operation between these two bodies by making sure that each practitioner has a clear understanding of the mechanism that has been evolved and to urge that it be used as designed. This is the only way by which defects can be revealed and further improvements brought about.

That the present is always the product of the past is, of course, true of this subject, and no statement of the Workmen's Compensation Board situation will be complete without some reference to the steps of its development. For this it is necessary to go back into history a little over ten years. The following abstract of a memorandum in the files of the Manitoba Medical Association of 1924 serves well as a starting point.

The memorandum is really the report of the committee that was appointed to inquire into and remove the cause of the friction that had been growing between practitioners and the Workmen's

Compensation Board. In substance, it found that the main cause of the trouble was the handling of consultations. The custom had grown up of quietly sending cases to other medical men for examination and even treatment or operation without any notice to the man in attendance. The defects of this arrangement were dwelt upon and the commission urged to adhere as far as possible to the traditional custom of the medical profession. It was further proposed that the commission should appoint a **board of official referees from nominations to be submitted by the Manitoba Medical Association**, who would act regularly as consultants on such cases, and the committee in effect promised that, if such a proposal were adopted, it would revive a spirit of co-operation in the medical profession — which was not very evident at that time. Another matter that was discussed was the treatment of injuries by the medical officer. The medical representatives contended that this was contrary to the spirit of the Act.

Following the presentation of the above communication to the W.C.B., the Attorney-General and the Compensation Board Commissioners, with the medical officer of the Board, met the president and secretary of the Manitoba Medical Association and the Buffer Committee in conference, and discussed the points at issue.

The proposal of a permanent Referee Board gave rise to some hesitation and considerable discussion, but eventually the Commissioner agreed to give the suggestion of the Association a practical trial for a year.

Upon the matter of **direct treatment of minor injuries by the medical officer** of the Board, the Commissioner made in substance the following statements: . . . that the Workmen's Compensation Board made no direct profit from retailing medical service; the actual **cost** only of such service was charged, and on this account the claim that this arrangement constituted a special levy upon the medical profession did not hold; that the period of disability in the type of cases treated is three times as long under the care of private practitioners as it is under the care of the medical officer of the Board and the expense to the Board is more than three times as great; . . . that the minimum total charge of five dollars for the most minor injury was excessive, and greater than would be the charge for similar service in private practice; . . . that treatment by the medical officer greatly facilitated the work of the Board by securing prompt reports and supervision of injuries of this character which were otherwise so often neglected as to lead to serious results.

The medical representatives found themselves unable to controvert these statements and their final report to the Manitoba Medical Association

Executive concluded with the following paragraph: "Before the profession can reasonably ask for a change in the present arrangement of the Board for the treatment of minor injuries, it must devise some way by which it can render at least equally good service at no greater cost. Certain of the facts cited, notably, the length of disability of patients under the care of a private practitioner, and the unnecessary expense to the Board caused by this, are a serious reflection upon the general treatment of minor injuries."

There are several points in the above memorandum that should be noted. The Commissioners **accepted** the view of the medical representatives regarding consultations, and agreed to follow the established custom as far as possible in future. They have **adhered** to this.

The Commissioners agreed to the recommendation of the medical representatives for the formation of a Referee Board, and they **accepted the method of appointment** that was suggested, i.e., from nominations submitted by the Executive of the Manitoba Medical Association. This provision afforded an open channel by which the viewpoint of the organized profession could be presented to the Board and any necessary adjustments easily made as they arose. The extreme value of such arrangement with a body so important as the Workmen's Compensation Board is plainly evident at the present time. As far as can be learned, this arrangement formed a precedent on this continent. It was within the legal powers of the Commissioners to refuse to make it. Yet, it is a matter of record that the privilege of these nominations, which were to be submitted each year by the Executive of the Manitoba Medical Association, **was allowed to lapse for six or seven years**. The Executive offered no new names during that time, and the Workmen's Compensation Board carried on as well as it could with the list it had been given.

Further, the Board presented the medical representatives with serious criticism upon the general treatment of minor injuries which prevailed at the time and which was deflecting the treatment of such cases away from the general profession. It is not on record that any action was taken regarding this. The profession rested contentedly under this indictment and no concerted effort was made to improve the situation.

In September, 1926, the Buffer Committee submitted another report, which is also essential to this history, as follows:

"During the past year your committee has had occasion to act with the Compensation Board Commission in only a few matters, and these chiefly of a routine nature, such as the adjustment of fees, etc.



"Some of the work previously within the scope of this committee has passed naturally into the hands of the Referee Board. This Board has now been functioning for over a year; during that time your committee has not received, either from the members of the profession or the Commission, a single unfavorable criticism regarding it. At the last conference marked satisfaction was expressed at the degree to which this Board facilitated the work. In as much as the manner of appointment of this Referee Board is something of a precedent, your committee regards it as highly gratifying that the responsibility assumed by the profession in this relation has been thus far so well discharged."

### Fees

"In dealing with the Compensation Board upon the matter of fees, your committee has been governed by what they regard as an important principle. Recognizing that this service is primarily economic, the committee has been disposed to accept adjustment in the fee schedule whenever reduction still leaves it possible to maintain a high standard of service. A comparison of the Manitoba schedule with those of other provinces shows that the adjustment of some items may fairly be made. The duty of the profession in this matter must be mainly to safeguard the quality of the service they render.

"Modifications of the existing schedule have been recommended by the committee and approved by the Executive."

### Exorbitant Fees or Unfair Charges

"This matter was dealt with in the last annual report of this committee. Instances of unfair charges, into the details of which it is unnecessary to enter, recur far too often. It would appear that the offenders are chiefly among the younger men, and that economic pressure is the main factor responsible; but it should be thoroughly realized that the Board has excellent machinery for keeping itself informed of the little details of such matters and ample power to protect itself from exploitation. One of the means available is to strike the culprit's name from the list of those eligible for Compensation Board work. It should be further made known that, if the Board is forced to take such action, it will be with the concurrence of representatives of the Medical Association. There is every indication that bodies such as the Workmen's Compensation Board will, in time, steadily broaden their various fields of activity. As the medical profession may expect to be involved in this in equal measure, it is essential for the ultimate interest and prestige of its members that the highest standard of ethics and efficiency be strictly maintained."

"This report would be incomplete if it failed to refer to the harmony which has marked the relations of the medical profession and the Compensation Board during the past year."

The foregoing report does not seem to call for explanation or comment other than to point out that those who have had trouble with the Ontario Board will find therein an explanation of the conditions for recognition and for payment which were set by the Board, and which should be followed until something better can be obtained. Other reports were made from time to time which were generally brief repetitions of the foregoing.

The problems presented to the Buffer Committee fell rather naturally into two different classes which, for convenience, are termed "economic" and "ethical." The distinction between these and the need for different methods of handling was not so manifest in the beginning as it later became.

The first class, called "economic," comprises such matters as the arrangement of general fee schedules, the rendering of assistance to the Board in deciding as to diagnosis and disability, and the adjustment of differences of opinion regarding equitable charges, character and duration of attendance, etc. Matters of this sort are part of the daily routine of the Board, and unless they are promptly adjusted, dissatisfaction tends to accumulate and eventually becomes a source of friction between the two bodies. The difference in outlook between medicine and the Compensation Board must be borne in mind. The Board as a Government organization is compelled to work to schedules and categories, and it has its own troubles in attempting to follow rigid classification in a field like medicine, which is subject to constant change. No relationship can be defined which will remain fixed. A considerable degree of elasticity will always be essential.

The principles which the Buffer Committee followed in its negotiations can be stated briefly. They were:

1. To place the standard of medical service before other considerations and to assume that the remuneration will be in general adequate, and ultimately in direct proportion to the standard of service maintained.

2. To assume that if, on the whole, the present return is regarded as adequate, then minor inequities should be endured or adjusted amicably as soon as possible.

3. That such adjustments are best made through the recognized medical organization.

The Buffer Committee never possessed any real power; its function was that of a "go-between." As such, it served a useful purpose during the formative period, that is to say, during the time required to analyze its vague tasks and devise

some more direct and effective means for discharging them.

The time seemed to have arrived last year for some improvement in the channel of communication between the Manitoba Medical Association and the Workmen's Compensation Board. This was fortunately to hand in the existing Referee Board. This Board, which was at the first intended to deal only with diagnosis and disability, had proved itself to be in practice such a convenient instrument, that it had already been asked to settle informally many other matters. By mutual agreement with the Workmen's Compensation Board, the constitution of the Referee Board has been somewhat altered so as to secure more systematic rotation of membership, according to the suggestion of the President of the Manitoba Medical Association, Dr. J. C. McMillan, whose interest and assistance were of great value in the negotiations. It was not intended in the beginning that appointments to the Referee Board should be permanent, but they very nearly became such through neglect to supply the Board with new names. The tenure of office has been set at two years, the appointments being made every second year, the senior member to act as chairman during his last two years in office. This is expected to provide the necessary continuity to make it efficient. It has been agreed that the medical officer of the Board may, at his discretion, alter the composition of the Referee Board if it is found necessary for special cases.

(At joint sessions with the Commission, it has been the accepted custom for the medical officer of the Workmen's Compensation Board to act as chairman.)

By resolution of the Executive of the Manitoba Medical Association, the Referee Board has been formally assigned the responsibility of caring for the economic interests of the profession in its relation with the Workmen's Compensation Board. Its duties include not only listening to complaints from the Workmen's Compensation Board, but presenting those of the profession. It is expected to function as follows:

In the case of a difference of opinion with the Board upon any of the details referred to, which cannot be adjusted by a brief direct discussion, the practitioner should submit to the Referee Board a clear written statement of his case. This should be done on principle (no matter how small the amount involved may be) if, after consideration, he concludes he has been dealt with unfairly. This communication should be forwarded to the secretary of the Manitoba Medical Association for the attention of the chairman of the Referee Board. The claim will then be considered by the Board, and if it seems well based

they will try to secure redress, and if this is not obtainable the reason will be explained.

Individual practitioners seem prone to struggle with these matters by themselves. This is not a very intelligent policy. Individual efforts are always handicapped from the start by the peculiar strength inherent in organization itself and a subconscious appreciation of this causes unfavorable decisions to rankle, even though they may be just. Organization should meet organization. When it has been provided, it should be used. If it does not function properly, it should be amended until it does so. Verdicts from the arbitration of this impartial body will be received by the profession in a sporting spirit and accepted as final; but it is a futile gesture to set up machinery if we fail to use it for its purpose.

During the last four or five years, the problems classed as "ethical", have been referred to with increasing emphasis. These seriously affect the good name of the profession and have been difficult to deal with. They concern such matters as exorbitant charges, false certification, collusion and actual or attempted fraud. In every case the complaint has been substantiated by the reports of investigation and sworn documentary evidence.

When the committee was first faced with these matters, it advised that they be immediately passed to the College of Physicians and Surgeons for disciplinary action. The answer was that the President of the College of Physicians and Surgeons took the stand that no action could be taken until a police court conviction had been secured. The Commissioner declined to resort to such measure. It seemed as if nothing could be done. The Buffer Committee could merely sit "with such countenance as it could command" and listen to the evidence. Three times this situation was presented to meetings of the Manitoba Medical Association and the College of Physicians and Surgeons within as many years, and some action was urged to enable the profession to clear its record. The lines of action discussed were:

1. To agree that the Compensation Board should have the power to black-list offenders. This would be not only assuming a serious legal responsibility, but it would also mean delegating to a lay body a measure of licensing power of which the College of Physicians and Surgeons has been made the sole trustee. The Buffer Committee was not prepared to assume such responsibility, and it was not recommended.

2. The Buffer Committee did suggest that, if the disciplinary power of the College of Physicians and Surgeons under the Act was so restricted that it was unable to deal effectively with the situation, the Act should be re-opened and power

to this end secured. Discussion of this proposal brought from members of the Council the public assurance that the power under the present Act was ample for the purpose, that a police court conviction never had been essential, and that the Council was eager to proceed against any offender brought to its notice.

Resting upon this assurance, the Buffer Committee recommended to the Executive of the Manitoba Medical Association that all problems of this character should, for the future, be passed directly to the Council of the College of Physicians and Surgeons. It is obvious that, from the beginning, the Council has been the only body with the power to deal with these matters. It was instituted and empowered for that purpose. From the standpoint of medicine, as a guild, it has no duty more urgent than that of maintaining the good name of the profession. Inertia and defective organization have caused some default in this in the past, and in spite of the anxiety of nearly all to keep the reputation of the profession above reproach, it has been allowed to suffer. It is not sufficient for the College of Physicians and Surgeons to wait passively for external stimulation; as the only body with the necessary power, it must carry the full responsibility and the initiative must rest with it. The arrangements for this are still defective. The initiative is still left with either the Workmen's Compensation Board or the Referee Board. If these bodies must choose which instances of ethical infraction should be submitted to the Council and which should not be, they must undertake, to that extent, the function of judges. That is the prerogative of the Council; it is an obligation that other bodies are in no position to discharge, and they should not be asked to assume it. It is suggested that the

Council, in the exercise of its authority, is fully capable of discriminating between major and minor infractions of the code and dealing appropriately with them, and that some machinery should be devised to bring all such matters automatically to its attention.

#### Summary

The Buffer Committee goes out of existence.

The functions it has performed are divided as follows:

The economic problems become the care of the revised Referee Board (via the secretary of the Manitoba Medical Association).

The ethical problems become the responsibility of the Council of the College of Physicians and Surgeons.

With the exception of the one weak link mentioned, the medical profession and the Workmen's Compensation Board seem to have reached, for the moment at least, a sound arrangement for effective co-operation. To this end, the willing assistance of Colonel Newcombe, Chief Commissioner, and Dr. A. J. Fraser, Chief Medical Officer, have been of invaluable aid.

(Signed) F. D. McKenty, Chairman.

Dr. F. D. McKenty,  
312 Medical Arts Bldg.,  
Winnipeg, Manitoba.

June 8th, 1925

Dear Dr. McKenty:

I have gone over memorandum with Dr. Fraser and would say that same seems to set out satisfactorily the position of the Board with respect to the matters covered.

Yours truly,

The Workmen's Compensation Board.

(Signed) N. Fletcher,

Assistant to Commissioner and Secretary.

#### The School-Child's Breakfast

Many a child is scolded for dullness when he should be treated for undernourishment. In hundreds of homes a "continental" breakfast of a roll and coffee is the rule. If, day after day, a child breaks the night's fast of twelve hours on this scant fare, small wonder that he is listless, nervous or stupid at school. A happy solution to the problem is Pabulum. Pabulum furnishes protective factors especially needed by the school-child—especially calcium, iron and the vitamin B complex. The ease with which Pabulum (or Pabena) can be prepared enlists the mother's co-operation in serving a nutritious breakfast. This palatable cereal requires no further cooking and can be prepared simply by adding milk or water of any desired temperature.

#### Microfilm Service

Microfilms of journal articles not on file locally may be obtained from the Army Medical Library, Washington, D.C., U.S.A., of material on file there. There is no charge for this photoduplication service which is "... intended to supplement the services of the local library and not in any way supplant them ..."

All filming is done on special request for the particular article desired. The publication "Current List of Medical Literature" which lists the material received at the Army Medical Library is on file here.

Microfilms will be furnished to individuals requesting them, but the Army Medical Library prefers that the requests will be sent through a medical library.

For further information enquire at the Medical Library. 29 545.



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AT THE  
ONSET



Administer two tablespoonfuls of Kaomagma Plain in a little water.

AND



Follow this with one tablespoonful of Kaomagma Plain after every bowel movement.

THEN



When stools become consolidated, one tablespoonful of Kaomagma with Mineral Oil three times daily may be indicated.

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## Personal Notes and Social News

Dr. Fred A. Young's only daughter, Katherine Elizabeth, was married on April 23rd, 1946, at the Cardinal's Chapel, St. Mary's Cathedral, Sydney, Australia, to William Archibald Stewart, son of Mr. and Mrs. C. A. Stewart, of Riviere du Loup, Quebec.

Dr. R. D. Bird of Brandon was elected President of the Brandon branch of the Manitoba Game and Fish Association.

Dr. and Mrs. E. T. Etsell, whose wedding took place in Winnipeg, April 11th, 1921, celebrated their silver wedding anniversary on April 13th at their residence, 111 Gerard Street, where a host of friends gathered in honour of the event and to wish them *souhaits de bonheur et de bonne santé*.

Dr. and Mrs. M. Carleton, St. James, Man., are happy to announce the birth of a daughter (Linda Anne) on April 25th, 1946, at St. Joseph's Hospital.

Dr. and Mrs. K. J. Austmann's twin daughter, Thora Clara, was married on May 4th to Edwin Bernard Purdy, youngest son of Mr. and Mrs. Ira Purdy of Winnipeg.

Dr. and Mrs. P. K. Tisdale take pleasure in announcing the birth of a son, John Paul, on April 28th, 1946, at the Winnipeg General Hospital.

Dr. I. O. Fryer has been appointed provincial coroner, succeeding the late Dr. W. R. Gorrell.

Dr. G. S. Baldry, recently demobilized from the R.C.A.M.C., is now in civilian practice at 616 Medical Arts Building.

Dr. J. H. Conklin, formerly of 201 Hampton Street, St. James, is now located at 12B Locarno Apartments, Winnipeg.

Dr. J. M. Ridge, formerly of Hodgson, Man., has moved to The Pas, Man.

## Medical Happenings for May

### Wednesday, 1—

Tumor Clinic, Winnipeg General Hospital,  
9:00 a.m.

### Thursday, 2—

Luncheon, Winnipeg General Hospital, 12:30 p.m.

### Friday, 3—

Luncheon, Misericordia Hospital, 12:30 p.m.

### Wednesday, 8—

Tumor Clinic, Winnipeg General Hospital,  
9:00 a.m.

### Wednesday, 8—

Meeting, Council, Winnipeg Medical Society,  
12:30 p.m.

### Thursday, 9—

Ward Rounds, Children's Hospital, 11:00 a.m.

### Thursday, 9—

Luncheon, St. Boniface Hospital, 12:30 p.m.

### Friday, 10—

Tumor Clinic, St. Boniface Hospital, 10:00 a.m.

### Wednesday, 15—

Tumor Clinic, Winnipeg General Hospital,  
9:00 a.m.

### Thursday, 16—

Ward Rounds, Children's Hospital, 11:00 a.m.

### Thursday, 16—

Luncheon, Winnipeg General Hospital, 12:30 p.m.

### Friday, 17—

Tumor Clinic, St. Boniface Hospital, 10:00 a.m.

### Friday, 17—

Meeting, Winnipeg Medical Society, 8:15 p.m.,  
Medical College.

### Tuesday, 21—

Luncheon, Grace Hospital, 12:30 p.m.

### Tuesday, 21—

Luncheon, St. Joseph's Hospital, 12:30 p.m.

### Wednesday, 22—

Tumor Clinic, Winnipeg General Hospital,  
9:00 a.m.

### Thursday, 23—

Ward Rounds, Children's Hospital, 11:00 a.m.

### Thursday, 23—

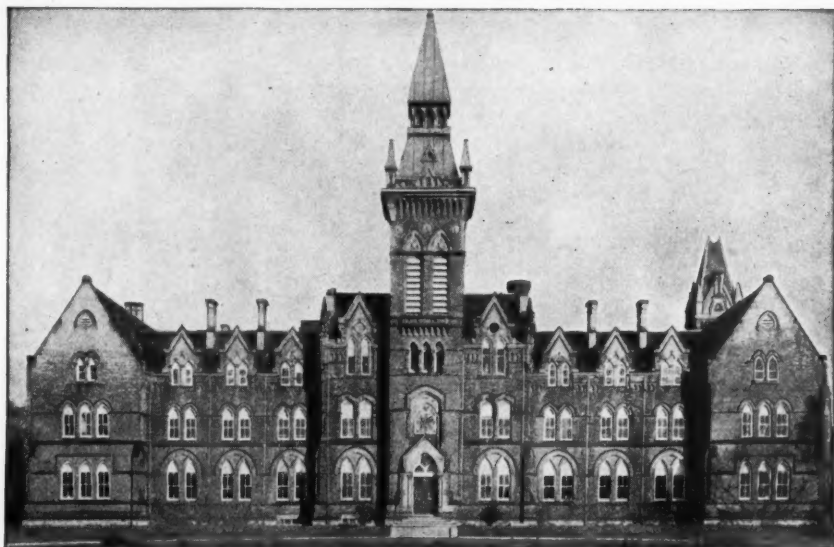
Luncheon, St. Boniface Hospital, 12:30 p.m.

### Friday, 24—

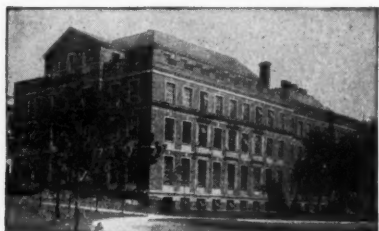
Tumor Clinic, St. Boniface Hospital, 10:00 a.m.

### Friday, 24—

Luncheon, Victoria Hospital, 12:30 p.m.



*Spadina Crescent Building, providing administration, research laboratories and the production of Penicillin.*



*School of Hygiene Building, a portion of which accommodates additional research laboratories and the preparation of Insulin and other glandular products.*



*Virus Research Laboratory, one of the research laboratories in the Dufferin Division, a 145-acre farm property 12 miles north of Toronto.*

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In 1914 the preparation and distribution of essential public health biological and related products were undertaken in the University of Toronto in the Antitoxin Laboratory. In 1923 the greatly expanded undertakings were named Connaught Laboratories.

The work of the Laboratories is well known because of the widespread distribution of products. Throughout the years, however, research in preventive medicine has been a primary function. The number of research undertakings has kept pace with the growth of the Laboratories and to-day more than fifty studies are in progress.

To express the fundamental interest of the Connaught Laboratories in research, the Board of Governors of the University of Toronto has approved of the inclusion of the words "Medical Research" in the name of the Laboratories, which will now be known as "Connaught Medical Research Laboratories."

The preparation and distribution of biological and related products will be continued.

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**Department of Health and Public Welfare**  
**Comparisons Communicable Diseases — Manitoba (Whites and Indians)**

DISEASES	1946		1945		TOTALS	
	Feb. 24 to Mar. 23	Jan. 27 to Feb. 23	Feb. 25 to Mar. 24	Jan. 28 to Feb. 24	Jan. 1 to Mar. 23, '46	Jan. 1 to Mar. 24, '45
Anterior Poliomyelitis		1		2	1	3
Chickenpox	78	131	213	201	383	685
Diphtheria	14	16	33	45	49	105
Diphtheria Carriers	2	3	2	9	6	19
Dysentery—Amoebic					1	
Dysentery—Bacillary					1	1
Erysipelas	4	5	9	3	16	18
Encephalitis				1		1
Influenza	36	41	30	24	99	77
Measles	23	13	28	67	75	147
Measles—German	1	1	1	3	3	8
Meningococcal Meningitis	3		2	3	5	7
Mumps	348	148	229	172	613	469
Ophthalmia Neonatorum						
Pneumonia—Lobar	5	9	12	13	30	39
Puerperal Fever						
Scarlet Fever	49	46	96	94	155	260
Septic Sore Throat	7	3	2	3	14	6
Smallpox						
Tetanus						
Trachoma						
Tuberculosis	48	40	44	51	115	111
Typhoid Fever			2	17		21
Typhoid Paratyphoid				2		2
Typhoid Carriers			1			1
Undulant Fever			1	2	1	4
Whooping Cough	9	16	46	42	57	132
Gonorrhoea	205	184	163	125	577	405
Syphilis	53	58	45	65	169	152
Diarrhoea and Enteritis, under 1 yr.	8	7			22	

**DEATHS FROM COMMUNICABLE DISEASE**

For the Month of February, 1946

DISEASES (White Cases Only)	*732,000 Manitoba	*3,825,000 Ontario	*906,000 Saskatchewan	*2,972,000 Minnesota	*641,000 North Dakota
Anterior Poliomyelitis		1			
Chickenpox	78	978	119		26
Diarrhoea and Enteritis, under one	8				
Diphtheria	14	33	4	32	5
Dysentery—Amoebic		1		4	
Dysentery—Bacillary		1			
Diphtheria Carriers	2				
Encephalitis—Epidemica					
Erysipelas	4	7	2		1
Influenza	36	149		8	40
Jaundice—Infectious		11	1		
Measles	23	6,162	21	160	45
Measles—German	1	158	10		
Meningococcal Meningitis	3	12	2	15	3
Mumps	348	1,086	41		
Pneumonia—Lobar	4		5		47
Scarlet Fever	49	276	12	232	45
Septic Sore Throat	7	8			1
Smallpox					
Trachoma					1
Tuberculosis	39	260	69	13	13
Typhoid Fever		8	2	2	
Typhoid Paratyphoid		8			
Undulant Fever				29	
Whooping Cough	9	206		25	
Gonorrhoea	205	664			63
Syphilis	53	376			26

\*Approximate population.

**Urban**—Cancer, 44; Diphtheria, 1; Influenza, 6; Pneumonia Lobar, 2; Pneumonia (other forms), 9; Syphilis, 3; Tuberculosis, 4; Hodgkin's Disease, 2; Septic Sore Throat, 1; Cerebrospinal Meningitis, 1; Septicemia, 1; Diarrhoea and Enteritis, 1. Other deaths under 1 year, 16. Other deaths over 1 year, 184. Total, 200.

**Rural**—Cancer, 25; Diphtheria, 1; Dysentery, 1; Influenza, 6; Pneumonia Lobar, 2; Pneumonia (other forms), 8; Syphilis, 1; Tuberculosis, 13; Septic Sore Throat, 2; Diarrhoea and Enteritis, 4. Other deaths under 1 year, 13. Other deaths over 1 year, 129. Total, 142.

**Indians**—Pneumonia (other forms), 9; Tuberculosis, 3; Septicemia, 2. Other deaths under 1 year, 3. Other deaths over 1 year, 2. Total, 5.

**Diphtheria** is still too prevalent in Manitoba. A letter has gone out to all medical officers of health asking for an increased effort to obtain a higher percentage of persons immunized against this disease. All doctors should take an active part in this campaign to save lives and suffering from a preventable disease.

**Mumps**—Winnipeg has been suffering quite an epidemic for the past few weeks!

**Typhoid Fever**—Since the above report was compiled an outbreak of four cases with one death has been reported from the Rural Municipality of Rhineland. These cases were traced to a female carrier who had the disease in 1927. Carriers are the great problem in spread of Typhoid Fever.



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## Doctors Returned to Civilian Practice From Armed Forces

The following doctors have been discharged from the services and are now back in practice. Their office addresses and telephone numbers are given so that you may easily inform their old patients where they may be found:

Name	Address	Telephone No.
Adamson, Dr. Gilbert L.,	Winnipeg Clinic, Winnipeg	97 284
Adamson, Dr. J. D.,	Winnipeg General Hospital	87 681
Alexander, Dr. Walter,	214 Medical Arts Bldg., Wpg.	95 300
Allen, Dr. C. S.,	216 Panama Court, Winnipeg	41 185
Anderson, Dr. Julius,	185 Maryland St., Winnipeg	404 065
Austman, Dr. K. J.,	704 McArthur Bldg., Winnipeg	95 826
Avren, Dr. S. S.,	416 McKenzie St., Winnipeg	59 422
Baldry, Dr. Geo. S.,	616 Medical Arts Bldg., Wpg.	94 980
Barrie, Dr. J. G.,	11 Rosewarne Ave., St. Vital	204 643
Bellam, Dr. S.,	400 Aberdeen Ave., Winnipeg	54 679
Bell, Dr. P. G.,	Deer Lodge Hospital, Winnipeg	62 821
Bennett, Dr. Wm. J.,	12 Newhaven Apts., Winnipeg	33 772
Benoit, Dr. C. F.,	114 Claremont Ave., Norwood	202 470
Berbrayer, Dr. Peter,	205 Boyd Bldg., Winnipeg	94 112
Berger, Dr. M.,	428 Anderson Ave., Winnipeg	
Black, Dr. Geo. M.,	10 Simcoe Apts., Winnipeg	
Bleeks, Dr. Cherry K.,	105 Medical Arts, Bldg., Wpg.	93 273
Bottomley, Dr. H. W.,	Winnipeg Clinic, Winnipeg	97 284
Boyd, Dr. Wm. J.,	1012 Ingersoll St., Winnipeg	24 427
Brotman, Dr. E. H.,	1137 Portage Ave., Winnipeg	36 500
Brown, Dr. M. M.,	508 Medical Arts Bldg., Winnipeg	93 889
Bruce, Dr. J. D.,	20 Buckingham Apts., Winnipeg	96 780
Burch, Dr. J. E.,	Winnipeg Clinic, Winnipeg	97 284
Bruser, Dr. D. M.,	58 Noble Ave., Winnipeg	
Cadham, Dr. R. G.,	City Hall, Winnipeg	849 122
Carleton, Dr. M.,	603 Boyd Bldg., Winnipeg	94 763
Chestnut, Dr. H. W.,	25 Knappen Ave., Winnipeg	
Clark, Dr. C. W.,	216 Medical Arts Bldg., Winnipeg	94 354
Cohen, Dr. R.,	600 Boyd Bldg., Winnipeg	93 275
Coke, Dr. L. R.,	238 Spence St., Winnipeg	
Collins, Dr. D. R.,	Internes' Quarters, Winnipeg General Hospital, Winnipeg	87 681
Cooper, Dr. Ross H.,	212 Medical Arts Bldg., Winnipeg	93 103
Corrigan, Dr. C. E.,	307 Waterloo St., Winnipeg	401 271
Cram, Dr. J. B.,	409 Power Bldg., Winnipeg	95 165
Croll, Dr. L. D.,	661 Broadway, Winnipeg	72 138
Daniel, Dr. E.,	Winnipeg General Hosp., Winnipeg	87 681
Davidson, Dr. Kenneth,	6 Medical Arts Bldg., Wpg.	95 683
Davidson, Dr. A. M.,	6 Medical Arts Bldg., Winnipeg	95 683
Doupe, Dr. J.,	592 Stradbroke Ave., Winnipeg	46 501
Downey, Dr. J. L.,	333 Bartlett Ave., Winnipeg	46 751
Easton, Dr. S.,	216-7 Curry Bldg., Winnipeg	26 477
Edwards, Dr. K. N.,	139 Girtton Boulevard Tuxedo, Man.	
Elliott, Dr. M. R.,	141 Ferndale Ave., Norwood	
Elvin, Dr. Norman L.,	314 Medical Arts Bldg., Wpg.	95 317
Eshoo, Dr. H.,	Misericordia Hospital, Winnipeg	97 035
Evoy, Dr. G. H.,	264 Edmonton St., Winnipeg	94 335
Fahrnl, Dr. Gordon S.,	105 Medical Arts Bldg., Wpg.	93 273
Fairfield, Dr. G. C.,	Portage la Prairie, Man.	
Findlay, Dr. J. A.,	Winnipeg Gen. Hosp., Winnipeg	87 681
Flett, Dr. R. O.,	203 Medical Arts Bldg., Winnipeg	92 934
Franks, Dr. Fred,	492 Mountain Ave., Winnipeg	
Govan, Dr. W. R.,	Abbott Clinic, 409 Power Bldg., Winnipeg	95 165
Green, Dr. P. T.,	201 Hampton St., St. James, Man.	61 622
Guest, Dr. W. C.,	151 Yale Ave., Winnipeg	
Gyde, Dr. M. C.,	St. Pierre, Man.	
Hall, Dr. C. W.,	1328 Pembina Highway, Fort Garry, Man.	49 498
Hamilton, Dr. Glen F.,	408 Medical Arts Bldg., Wpg.	93 846
Hart, Dr. W. J.,	Deer Lodge Hospital, Winnipeg	62 821
Hastings, Dr. D. J.,	634 Somerset Bldg., Winnipeg	98 727

Helgason, Dr. R. E.,	Glenboro, Man.	
Henneberg, Dr. C. C.,	302 Medical Arts Bldg., Wpg.	92 710
Hillsman, Dr. J. A.,	308 Medical Arts Bldg., Winnipeg	97 329
Hitesman, Dr. R. J.,	512 Medical Arts Bldg., Wpg.	94 808
Holland, Dr. T. E.,	203 Medical Arts Bldg., Winnipeg	96 948
Houston, Dr. A. B.,	937 Warsaw Ave., Winnipeg	45 925
Hudson, Dr. J. E.,	Hamiota, Man.	
Jacks, Dr. Q. D.,	410 Medical Arts Bldg., Winnipeg	95 309
Jauvoish, Dr. S.,	206 Boyd Bldg., Winnipeg	93 240
Jones, Dr. E. A.,	Ste. 5, 117 Bryce St., Winnipeg	43 283
Kiernan, Dr. M. K.,	Winnipeg Gen. Hosp., Winnipeg	87 681
Kilgour, Dr. J. M.,	Winnipeg Clinic, Winnipeg	95 284
Klass, Dr. A. A.,	132 Matheson Ave., Winnipeg	55 022
Kobrinsky, Dr. M. T.,	968 Strathcona St., Winnipeg	71 498
Kobrinsky, Dr. Sam,	602 Medical Arts Bldg., Wpg.	95 875
Kobrinsky, Dr. Sydney,	505 Boyd Bldg., Winnipeg	93 912
Lansdown, Dr. L. P.,	Pine Falls, Man.	
Lazareck, Dr. T. L.,	618 Aberdeen Ave., Winnipeg	53 674
Leach, Dr. W. B.,	150 Alloway Ave., Winnipeg	71 921
Lebbetter, Dr. T. A.,	Winnipeg Clinic, Winnipeg	97 284
Leishman, Dr. J. D.,	400 Power Bldg., Winnipeg	96 234
Lerner, Dr. A. I.,	211 McIntyre Bldg., Winnipeg	
Loadman, Dr. B. E.,	Ste. 14A Pullmer Apts., Wpg.	43 601
Lotimer, Dr. L. E.,	Winnipeg Clinic, Winnipeg	97 284
Lund, Dr. P. C.,	Deer Lodge Hospital, Winnipeg	62 821
Lyons, Dr. R.,	420 Niagara St., Winnipeg	404 009
MacDonnel, Dr. J. A. K. (lady),	Winnipeg Clinic	97 284
MacKinnon, Dr. W. B.,	661 Broadway, Winnipeg	72 138
Maclean, Dr. Ian S.,	391 Overdale St., St. James, Man.	61 885
MacLeod, Dr. J. W.,	Winnipeg Clinic, Winnipeg	97 284
MacNeil, Dr. Robt. W.,	Children's Hospital, Winnipeg	37 271
MacNeil, Dr. Robt. W.,	Children's Hospital, Wpg.	37 031
Malkin, Dr. S.,	701 Boyd Bldg., Winnipeg	97 223
Malone, Dr. M. C.,	St. Boniface Hosp., St. Boniface	201 121
Margolese, Dr. J.,	414 Boyd Bldg., Winnipeg	24 541
Martin, Dr. J. H.,	St. Boniface Hospital, St. Boniface, Man.	201 121
Mathewson, Dr. F. A. L.,	308 Med. Arts Bldg., Wpg.	94 942
McFarlane, Dr. R. H.,	Internes' Quarters, General Hospital, Winnipeg	87 681
McFetridge, Dr. W. J. M.,	104 Arlington St., Winnipeg	
McIntyre, Dr. Donald N. C.,	303 Med. Arts Bldg., Wpg.	92 639
McKenty, Dr. J. Stewart,	141 Med. Arts Bldg., Wpg.	92 711
McKenty, Dr. Jack,	121 Girtton Blvd., Tuxedo, Man.	61 777
McKenty, Dr. V. J.,	205 Boyd Bldg., Winnipeg	94 112
McLandress, Dr. Murray,	Apt. "D" Brentwood Lodge, Winnipeg	42 490
McNicol, Dr. H. L.,	Deer Lodge Hospital, Winnipeg	62 821
McPhail, Dr. Ethel M.,	90 Roslyn Road, Winnipeg	
McTavish, Dr. Geo. B.,	206 Affleck Block, Winnipeg	98 620
Medovy, Dr. Harry,	401 Boyd Bldg., Winnipeg	93 849
Miller, Dr. I.,	St. Boniface Hosp., St. Boniface	201 121
Mitchell, Dr. J. R.,	Ste. 10 Fairhaven Apts., Winnipeg	72 187
Moffat, Dr. R. G.,	340 Borebank St., Winnipeg	
Moir, Dr. J. H.,	41 Springside Ave., St. Vital, Man.	205 543
Myers, Dr. R. F. M.,	15 Clement Block, Brandon, Man.	
Neilson, Dr. Clive,	404 Medical Arts Bldg., Winnipeg	94 041
Orchard, Dr. S. A.,	St. Boniface Hosp., St. Boniface	201 121
Perrin, Dr. M. B.,	Winnipeg Clinic, Winnipeg	97 284
Pickard, Dr. E. W.,	118 Lenore St., Winnipeg	
Pierce, Dr. M. M.,	354 Stella Ave., Winnipeg	54 134
Rabson, Dr. L. R.,	452 Ash St., Winnipeg	
Rafuse, Dr. E. R.,	320 Sherbrook St., Winnipeg	
Ramsay, Dr. F. G.,	378 Borebank St., Winnipeg	402 669
Revell, Dr. D. G.,	Winnipeg General Hospital, Wpg.	87 681
Richardson, Dr. R. W.,	105 Medical Arts Bldg., Wpg.	93 273
Ridge, Dr. J. M.,	Clearwater Indian Hospital, The Pas, Man.	
Riley, Dr. H. W.,	Winnipeg Clinic, Winnipeg	97 284
Rose, Dr. J. E.,	Winnipeg Gen. Hosp., Winnipeg	87 681
Rosenfield, Dr. V. L.,	405 Avenue Bldg., Winnipeg	97 141
Rumball, Dr. A. C.,	Deer Lodge Hospital, Winnipeg	62 827
Rusen, Dr. S. D.,	399 Machray Ave., Winnipeg	58 474

(Continued on Page 312)

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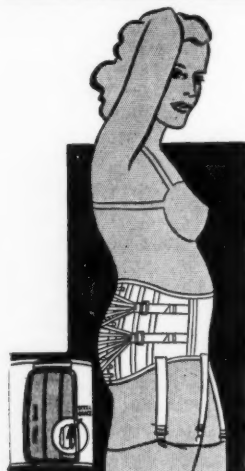
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Made of strong canvas provided with detachable special leather-covered pad in which is inserted two (2) rigid metal braces (one at each side of spine) giving ideal back support.

Adjustable by two (2) sets of draw straps. Front fastening.

Rochester Model 1938

Depth in front 7", depth in back 10½".

Made in stock sizes 30 to 42, or to special measurements.

Physicians Prescribe as "FISHERMADE" Model 1938

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219 KENNEDY STREET WINNIPEG  
Branches: EDMONTON and VANCOUVER

### Doctors Returned to Civilian Practice from Armed Forces

(Continued from Page 311)

Sandborn, Dr. B. S. E., Grace Hospital, Winnipeg	37 271
Scarrow, Dr. Hart G., Deer Lodge Hosp., Winnipeg	64 861
Schoemperlen, Dr. C. B., 216 Medical Arts Bldg., Wpg.	94 354
Smith, Dr. N. S. H., 275 Duffield St., St. James	63 224
Smith, Dr. F. Hartley, 86 Tache Ave., Norwood, Man.	203 993
Sommerville, Dr. A. N., 614 St. Mary's Rd., St. Vital	202 411
Sommerville, Dr. A. N., 614 St. Mary's Rd., St. Vital	
Stephens, Dr. Gordon M., 635 Henderson Hy., Wpg.	503 965
Stephenson, Dr. Earl, 409 Power Bldg., Winnipeg	95 165
Stewart, Dr. D. B., 30 Ferndale Ave., Norwood, Man.	205 298
Swartz, Dr. David, 303 Medical Arts Bldg., Winnipeg	92 639
Swan, Dr. R. S., 215 Medical Arts Bldg., Winnipeg	94 354
Tanner, Dr. A. R., 310 Medical Arts Bldg., Winnipeg	95 946
Taylor, Dr. C. H., 606 Boyd Bldg., Winnipeg	98 937
Tisdale, Dr. Paul K., Deer Lodge Hospital, Winnipeg	62 821
Walton, Dr. C. H. A., Winnipeg Clinic, Winnipeg	97 284
Walton, Dr. Fred A., 3 Locarno Apts., Winnipeg	45 719
Whelpley, Dr. E. H., 586 Ingersoll St., Winnipeg	39 061
White, Dr. O. J., Winnipeg General Hosp., Winnipeg	87 681
Whitehead, Dr. Robt. G. D., 91 Maryland St., Wpg.	
Willows, Dr. R. L., St. Boniface Hosp., St. Boniface	201 121
Winram, Dr. R. G., Ste. 51 Roslyn Apts., Winnipeg	
Brokovski, Dr. T. W.	Brandon, Man.
Brook, Dr. Joseph	Beausejour, Man.
Bissett, Dr. E. D. R.	Pine Falls, Man.
Brownlee, Dr. T. I.	Russell, Man.
Corbett, Dr. Connor A.	Crystal City, Man.
Crawford, Dr. C. S.	The Pas, Man.
Davidson, Dr. D. A.	Cartwright, Man.
Edmison, Dr. J. N., Manitoba Sanatorium	Ninette, Man.
Gendreau, Dr. L. P., Mental Hospital	Selkirk, Man.
Harris, Dr. R. S.	Viriden, Man.
Jacobs, Dr. A. L.	The Pas, Man.
Lippmann, Dr. H. H.	Beausejour, Man.
Luginsky, Dr. S. M.	Beausejour, Man.
North, Dr. W. H. C.	Viriden, Man.
Varverikos, Dr. E. D.	Selkirk, Man.
Watkins, Dr. R. T.	Brandon, Man.

### Free Library Postal Rate for the Medical Profession Within Manitoba

The Medical Library has a reduced postal rate for use on all loans of BOOKS and PERIODICALS mailed to the medical profession residing within the Province of Manitoba. When the borrower receives the loans, all that has to be done, is to **SAVE THE WRAPPER**, with the **LABELS** supplied by the library, and follow the instructions thereon. **NO POSTAGE** need then be **PAID**.

By the neglect of the study of humanities, which has been far too general, the profession of medicine loses a very precious quality.—William Osler.

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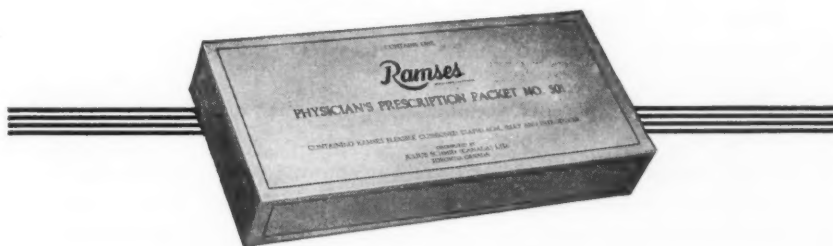
## EMPHASIS ON BARRIER ACTION

Authoritative opinion is increasingly inclined to the view that effective barrier action is the most dependable method of protection.

Dickinson<sup>1</sup> offers the opinion that jellies and creams used without a mechanical device have not proved fully dependable to block the external os.

The most acceptable means of securing effective barrier action with the utmost in comfort to the patient is provided by the "RAMSES"\* Prescription Packet No. 501.

1. Dickinson, R.L.: Techniques of Conception Control. Williams and Wilkins, Baltimore, 1942.



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# ANTISEPSIS

In rare conditions  
and  
everyday practice

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'The successful use of intrapleural lavage in a case of pyrothorax and bronchial fistula was described by Gilmour in 1937. The chosen antiseptic was Dettol which was used first in a concentration of 1 in 20 and later at full strength. At the end of each washout 20 c.c. of pure Dettol was left in the pleural cavity. Some of this was coughed up via the fistula, and some swallowed with no ill effect. The treatment was continued for 7 weeks, at the end of which the pleural space was obliterating, the fluid serous, and the patient's general condition very satisfactory. Recovery was uneventful.'\*

\*Santon Gilmour. (1937) *Tubercle*, vol. 19, p. 105.

**A** rare case—admittedly, yet not without some bearing on problems in everyday practice.

For what can reasonably be concluded about the attributes of an antiseptic that could be so used for so long and with such a result?

Obviously it must have been highly bactericidal; it must have been non-toxic, even at full strength and even on prolonged contact with the pleura and the gastrointestinal mucous membrane; it must also have been non-irritant and



non-corrosive, for otherwise it would have increased the vulnerability of the tissues to the infection and inhibited the natural processes of healing.

And in fact the clinical experience of over 12 years, in all the

contingencies of practice that call for rapid, effective and safe antiseptics, has shown that 'Dettol' does combine, in high measure, these fundamental attributes of an antiseptic for general use in medicine, surgery and obstetrics.

## 'DETTOL' OBSTETRIC CREAM

—a non-toxic highly bactericidal preparation sharing all the essential attributes of 'Dettol,' but with its own special place in obstetric practice.

Originally tested at Queen Charlotte's Hospital, London, in 1932, 'Dettol' Obstetric Cream is now in general use in maternity hospitals in Great Britain and throughout the Empire.

### *Rapidly lethal to hemolytic streptococci*

First, because of the antiseptic itself. 'Dettol' rapidly destroys—among other pathogenic organisms—the hemolytic streptococci responsible for most puerperal infections. It was this particular quality that led to its adoption as the routine antiseptic in London's great maternity hospital, Queen Charlotte's.

### *A persistent barrier to re-infection*

Secondly, because of the concentration. Applied to the skin 'Dettol' 30 per cent. not only destroys the organisms present, but forms a barrier to reinfection which lasts over two hours. In grossly contaminated cases it would naturally be applied at shorter intervals; but in routine practice two-hourly applications are more than adequate.

### *Intimate contact with skin and mucous membranes*

Thirdly, because of the vehicle. The pleasant creamy preparation remains in contact with the surface over which it is smeared. The continuity of the barrier to re-infection is thus assured.

### *Some clinical applications*

Possessing these special attributes, 'Dettol' Obstetric Cream is used by doctors and nurses in nearly every maternity hospital of the British Empire for the sterilization of the gloved hands and for their rapid re-sterilization during the conduct of labour. It is applied as a routine to the patient's vulva, perineum and thighs, and smeared periodically over the patient's hands.

The introduction of 'Dettol' Cream into the obstetric routine at Queen Charlotte's Hospital was immediately followed by a 50 per cent. decline (by comparison with the period immediately preceding) in the incidence of puerperal infection.

RECKITT & COLMAN (CANADA) LIMITED, PHARMACEUTICAL DIVISION, MONTREAL

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# SURBEX

(TRADE MARK)

HIGHER POTENCY

tablets

## FOR THE TREATMENT OF VITAMIN B COMPLEX DEFICIENCIES

SURBEX is supplied in convenient tablet form and is designed for treating moderate or severe deficiencies of Thiamine, Riboflavin or Nicotinamide accompanied by deficiencies of the other vitamin B complex factors contained in the tablet. One tablet supplies six times the minimum daily requirements of vitamin B<sub>1</sub> and three times that of riboflavin and nicotinamide. It is supplied in bottles of 100, 500 and 1000 tablets.

### EACH TABLET CONTAINS

Thiamine HCl	6 Mg.
(Vitamin B <sub>1</sub> , 2000 Int. Units)	
Riboflavin	6 Mg.
Nicotinamide	30 Mg.
Pyridoxine Hydrochloride (Vitamin B <sub>6</sub> )	1 Mg.
Pantothenic Acid (as Calcium Pantothenate)	10 Mg.
Liver Concentrate*	5 Grs.
Brewer's Yeast Dried*	2½ Grs.

\*For Other B Complex Factors

### SURBEX SYRUP

A palatable brewer's yeast syrup of high total B complex value.

Each cc contains:

Thiamine (vitamin B<sub>1</sub>) (133 Int. Units).. 0.4 mg.  
 Riboflavin (vitamin G) . . . . . 0.3 mg.  
 Nicotinamide value . . . . . 4 mg.  
 (pellagra-preventive effect equal to about 6.75 gm. of dried brewer's yeast.)

Pantothenic Acid . . . . . 0.5 mg.

The yeast extract used in this preparation contains other vitamin B Complex factors.

### SURBEX ELIXIR

Each cc. contains:

Thiamine Hydrochloride (vitamin B<sub>1</sub>) . 0.133 mg.  
 Riboflavin (vitamin G) . . . . . 0.133 mg.  
 Nicotinamide . . . . . 0.666 mg.

(pellagra-preventive effect equal to 2.75 Gm. fresh liver).

Other vitamin B complex factors as present in liver. Each fluid ounce is derived from approximately 40 Gm. (1½ ozs.) of fresh liver.  
 Alcohol 12.

ABBOTT LABORATORIES LIMITED • MONTREAL, CANADA

## College of Physicians and Surgeons of Manitoba

### (d) Representatives to the Medical Council of Canada.

Dr. J. S. Poole gave the following report:

"The Medical Council of Canada met in Ottawa on Wednesday, September 5th, 1945. The appointment of examiners was concluded, also the time and place of the examinations. The accelerated courses will cease in all the medical schools in one year.

"You asked your representatives to take up two points with the Medical Council of Canada, one regarding the enabling certificate, and the other the licensing of alien physicians.

"As regards enabling certificates, the opinion was unanimous that this was a Provincial matter, and that the Medical Council of Canada, which is simply an examining board, accepts for its examination all candidates who present a duly certified enabling certificate from some Provincial Licensing body.

"As to domicile, the opinion was that a Manitoba student registering in any province as a medical student, could demand an enabling certificate from that province as soon as he had completed his medical education. No matter from what province he came, if he presented his credentials to a provincial board, and they are satisfactory to them, he could be enrolled; then he could go on and take his medical examination in any province in Canada, and go back to the Province which had enrolled him for his enabling certificate.

"As regards alien physicians, it is purely a provincial matter. Ontario demands that they are British or Canadian citizens; others ask them to take one year in a medical school before being granted an enabling certificate.

"So as regards an enabling certificate, the Council considered it should be issued by the province which has enrolled him as a medical student; and as regards the alien physician, that also is a provincial matter. Most of the provinces ask them to write the fourth year examinations after spending a year in the medical school, after which they are issued an enabling certificate. Ontario asks that they be British or Canadian subjects.

"Licentiates of the Dominion Medical Council now number 8,913. Of these 531 were admitted this year, all but thirteen by examinations."

Dr. J. S. Poole.

Dr. Wm. Turnbull.

### Motion:

Moved by Dr. J. S. Poole, Seconded by Dr. Wm. Turnbull: "THAT the report of the Representatives to the Medical Council of Canada be accepted." Carried.

### (e) Representatives to the Committee on Admissions.

Dr. T. Digby Wheeler informed the Council that Dr. H. Bruce Chown was out of town for the first meeting of the Committee on Admissions, and that he substituted for him.

Dr. Chown presented the following report:

"In addition to the meeting reported to you by Dr. Wheeler there were two special meetings. I was not notified of the first one. It was held to fill vacancies caused by some already accepted applicants dropping out. The second meeting, which I attended, was for the same purpose.

"In the coming year the selection of students will be difficult. There are, at present, between 200 and 250 students in the second pre-medical year. From those who pass next spring the Committee must select sixty. The Committee has laid down two principles: first, that only residents of Manitoba will be accepted next year; second, that ex-service men and women will be given priority of selection. This does not mean that only ex-service men and women will be selected.

"I feel that the present method of selection is not satisfactory. The Committee had been promised a reasonably complete record of each applicant covering the requirements as set out by the Board of Governors. In point of fact practically all it had to go on, except in the case of some Saskatchewan students, was the scholastic standing. The comments of the Junior Division Instructors were of little or no help. Further what little information we did receive was provided at the last moment. The students were therefore selected on the basis of the one criterion of marks. On this basis approximately 30% of the students selected were Jewish.

"This fact has been brought to the notice of the Faculty by the Dean. It is a fact of which we must take cognizance. We have not progressed so far in this country, or this community, that our Jewish citizens are completely amalgamated and looked upon simply as Canadians. We still mark them off as a semi-separate group. This is an unhappy fact, but it is still a fact. Personally I have as high a regard on the average for my Jewish confreres as for my Gentile confreres, and a warm affection for many of them. I know that the position of the Jew in this community is a difficult one. I know that many fields of activity are closed to him, and that there is therefore a tendency to concentrate on those fields that are open. Medicine is, within limits, such a field.

"Personally I feel very unhappy about this situation. I cannot help but feel that concentration, such as is taking place in Medicine, can only lead to more and more bitter animosity. The

anti-Semitic outcry has been raised many times elsewhere and under other circumstances with, too often, the same horrible results. It can happen here. Last year, in the Legislature, the cry was raised, that the non-Jewish medical community, as represented by the Committee of Selection, was unfair to the Jewish community. This year in the Faculty the cry has been raised that the Jewish community is being unfair to the non-Jewish.

"We, as the Council of the College of Physicians and Surgeons, are interested in the selection of the future doctors for this Province. Within the limits of our authority it is our duty to see that the best men and women possible are directed into this field. We are also interested as citizens in the maintenance of peace, not just some distant peace in some distant land, but right here in our own Province. Can we find a peaceful, friendly and fair solution to our problem?

"Selection of students on a quota basis I do not like. It makes cleavages persist that should and must disappear. I would suggest that those with some authority in the Jewish community take this matter under consideration and attempt some selection themselves. Next I suggest that the Council consider whether it might not take steps to select and direct, early in their education, say at the Junior High School level, young men and women of promise into the field of Medicine. (I confess that, at the moment, I do not see clearly how this can be done.) For, whatever we may say, until vocational guidance becomes a true science, and selection can be placed on a sound, scientific basis, scholastic standing is almost certain to remain the major criterion of selection by any committee. Selection and direction by individuals, knowing well the attributes of particular young men and women, can be of great help in directing the best into this field.

"In this connection it seems to me that we are selecting our students too predominantly from the urban population. In the past a great many of our best physicians came from rural Manitoba. Today the rural student is frequently too scholastically handicapped, to succeed in the competitive examination for admission to the Medical School. I think that this results in a great loss to the profession, as well as being unfair to the rural student. Can we make representations to the Minister and support him in every sound move he makes to improve the educational opportunities of rural students?

"My next suggestion sounds silly, but so long as Latin is a compulsory prerequisite for admission to Medicine it serves to debar many excellent students. This is not because Latin is a particularly difficult subject, but it is because it must

be selected so early in a student's life, grade VIII. If a student reaches high school without Latin, and then decides that he or she wants to go into Medicine, he often is, even though in our eyes excellent material, strongly advised not to make the attempt. As things are now we are almost forcing immature boys and girls of 14 and 15 to decide whether they will or will not choose Medicine as a career. What is worse we are debarring many from later making that choice. I should like to see this Council initiate action to have Latin removed from the list of compulsory requisites for admission to Medicine, and so make the field of our selection wider.

"I ask your forgiveness for making such a long report, but I feel very strongly on this matter. A problem exists and we cannot make it disappear by closing our eyes to it. It must be solved. It is our duty to assist in that solution in as fair a manner as possible."

Respectfully submitted,

Dr. Bruce Chown.

#### Motion:

Moved by Dr. H. Bruce Chown, Seconded by Dr. T. Digby Wheeler: "THAT the report of the Committee on Admissions be adopted." Carried.

#### Motion:

Moved by Dr. Wm. Turnbull, Seconded by Dr. W. G. Campbell: "THAT a resolution be sent to the Board of Governors of the University of Manitoba, that 'Latin' be made an optional subject in preliminary and pre-medical education." Carried.

#### Motion:

Moved by Dr. J. S. Poole, Seconded by Dr. A. E. McGavin:

"THAT a resolution be sent to the Board of Governors of the University of Manitoba.

Whereas the Board of Governors of the University of Manitoba have established regulations for the selection of medical students.

And whereas the Committee on Selection has not had available to them information according to these regulations.

"THAT the Board of Governors be asked in the future to provide information upon which selection of medical students according to regulations can be made, and that such information be placed in the hands of the selection committee in sufficient time to allow them to exercise their judgment." Carried.

#### (f) Representative to the University Senate.

Dr. W. E. R. Coad presented the following report:

"During the past year, the Senate of the University of Manitoba held ten regular meetings of which eight were attended by your representative.



"Also within the same period there were no problems considered by the Senate that are of special concern or interest to the members of your organization."

Dr. W. E. R. Coad.

#### Motion:

Moved by Dr. W. E. R. Coad, Seconded by Dr. H. O. McDiarmid: "THAT the report of the representative to the University Senate be adopted." Carried.

#### (g) Representatives to the Cancer Institute.

Dr. W. G. Campbell presented the following report:

"During the past year the following fields of work have been maintained by the Institute:

(1) Radium and X-ray therapy services both of which are free to residents of Rural Manitoba; and available to residents of Greater Winnipeg on a sliding scale of fees based on the ability to pay.

(2) Cancer education has been greatly expanded in the rural areas, and now has approximately 500 voluntary organizations co-operating in this work.

(3) A biopsy service was provided for all rural medical men without charge. The demand for this service has increased 50% over the previous year.

(4) During the past year the Institute's Patient Follow-Up Service has been enlarged to include all cancer patients treated at the Winnipeg General Hospital, as well as its own patients treated at the Forlong Memorial."

#### Motion:

Moved by Dr. W. G. Campbell, Seconded by Dr. B. D. Best: "THAT the report of the representatives to the Cancer Institute be accepted." Carried.

#### 6. Election of Officers and Standing Committees.

##### Officers

##### (a) President.

Moved by Dr. T. Digby Wheeler, Seconded by Dr. W. E. R. Coad: "THAT Dr. C. W. Wiebe be appointed President." Carried.

##### (b) Vice-President.

Moved by Dr. I. H. Beckman, Seconded by Dr. T. Digby Wheeler: "THAT Dr. B. D. Best be appointed Vice-President." Carried.

##### (c) Registrar.

Moved by Dr. J. S. Poole, Seconded by Dr. A. A. Alford: "THAT Dr. W. G. Campbell be appointed Registrar." Carried.

##### (d) Treasurer.

Moved by Dr. A. A. Alford, Seconded by Dr. I. H. Beckman: "THAT Dr. T. Digby Wheeler be appointed Treasurer." Carried.

#### Nominating Committee to Strike Standing Committees

The President appointed the following members to be a Nominating Committee to strike Standing Committees:

Dr. J. S. Poole  
Dr. I. H. Beckman  
Dr. W. E. R. Coad

#### Standing Committees

##### (a) Registration Committee.

Dr. W. G. Campbell      Dr. Wm. Turnbull  
Dr. T. Digby Wheeler

##### (b) Education Committee.

Dr. A. A. Alford      Dr. B. D. Best  
Dr. W. F. Stevenson

##### (c) Finance Committee.

Dr. T. Digby Wheeler      Dr. N. G. Trimble  
Dr. Wm. Turnbull

##### (d) Legislative Committee.

Dr. J. S. Poole      Dr. A. E. McGavin  
Dr. H. O. McDiarmid      Dr. James Prendergast  
Dr. W. G. Campbell

##### (e) Discipline Committee.

Dr. A. A. Alford      Dr. C. B. Stewart  
Dr. A. E. McGavin      Dr. I. H. Beckman  
Dr. W. E. R. Coad

##### (f) Executive Committee.

Dr. Wm. Turnbull      Dr. J. S. Poole  
Dr. I. H. Beckman      Dr. H. O. McDiarmid  
Dr. W. G. Campbell

##### (g) Library Committee.

Dr. H. Bruce Chown

##### (h) Taxing Committee.

Dr. W. E. R. Coad      Dr. James Prendergast  
Dr. T. Digby Wheeler

#### Motion:

Moved by Dr. J. S. Poole, Seconded by Dr. A. E. McGavin: "That the appointments to the Standing Committees be adopted." Carried.

Dr. H. Bruce Chown relinquished the chairmanship in favor of the newly-elected President, Dr. C. W. Wiebe.

#### Election of Special Committees

##### (a) Representatives to the Manitoba Medical Association Executive.

Moved by Dr. T. Digby Wheeler, Seconded by Dr. I. H. Beckman: "THAT our representatives to the Manitoba Medical Association Executive be Drs. W. G. Campbell and H. O. McDiarmid." Carried.

**(b) Representatives to the Committee of Twelve.**

Moved by Dr. H. O. McDiarmid, Seconded by Dr. B. D. Best: "THAT our representatives to the Committee of Twelve be Drs. T. Digby Wheeler, Wm. Turnbull and I. H. Beckman." Carried.

**(c) Representative to the Committee on Admissions.**

Moved by Dr. H. O. McDiarmid, Seconded by Dr. T. Digby Wheeler: "THAT Dr. H. Bruce Chown be our representative to the Committee on Admission." Carried.

**(d) Representative to the University Senate.**

Moved by Dr. T. Digby Wheeler, Seconded by Dr. B. D. Best: "THAT Dr. W. E. R. Coad be appointed our representative to the University Senate." Carried.

**Appointment of Auditors and Scrutineers**

Moved by Dr. T. Digby Wheeler, Seconded by Dr. N. G. Trimble: "THAT Price, Waterhouse & Company be auditors for the College of Physicians and Surgeons of Manitoba for the year 1945-46." Carried.

Moved by Dr. T. Digby Wheeler, Seconded by Dr. H. O. McDiarmid: "THAT Dr. Elinor Black and Dr. A. R. Birt be appointed scrutineers for the election in 1946, and for the term of the elected Council." Carried.

**7. Communications, Petitions, Etc., to the Council.****(a) Communication from Dr. J. C. Hossack, Editor of The Manitoba Medical Review.**

A communication was received from Dr. J. C. Hossack, requesting that proceedings of the various Committees be printed in the Review.

**Motion:**

Moved by Dr. T. Digby Wheeler, Seconded by Dr. A. A. Alford: "THAT the proceedings of our meetings be published in the Manitoba Medical Review, and that the Registrar be instructed to obtain the necessary reprints for disposition to those requesting them." Carried.

**(b) Communication from the Manitoba Medical Library.**

A communication was received from Dr. Daniel Nicholson, Chairman of the Library Committee of the Faculty of Medicine, requesting the usual grant from the College of Physicians and Surgeons of Manitoba for the purchase of books and journals.

**Motion:**

Moved by Dr. T. Digby Wheeler, Seconded by Dr. H. Bruce Chown: "THAT the Council of the College of Physicians and Surgeons of Manitoba grant to the Medical Library Committee, the sum

of Seven Hundred and Fifty Dollars (\$750.00) for the year ending September 30th, 1946." Carried.

**(c) Communication from the Manitoba Medical Association. Re Grant for Extra-Mural Post-Graduate Work.**

A communication was received from the Manitoba Medical Association requesting a grant towards extra-mural post-graduate work in Manitoba.

**Motion:**

Moved by Dr. H. O. McDiarmid, Seconded by Dr. W. E. R. Coad: "THAT the College of Physicians and Surgeons of Manitoba grant a sum up to Three Hundred Dollars (\$300.00) to the Manitoba Medical Association for extra-mural post-graduate work." Carried.

**(d) Communication from the Manitoba Medical Association Re Combined Fees of the British Columbia Medical Association, the Canadian Medical Association, and the College of Physicians and Surgeons of British Columbia.**

A letter written by Dr. H. H. Milburn, of Vancouver, to Dr. R. I. Harris, Chairman of the Canadian Medical Association Committee on Constitution and Bylaws, and forwarded to the Registrar by Dr. P. M. McNulty, President of the Manitoba Medical Association, was presented before the Council.

**Motion:**

Moved by Dr. J. S. Poole, Seconded by Dr. A. E. McGavin: "THAT the letter be tabled." Carried.

**Amendment to the Above Motion:**

Moved by Dr. T. Digby Wheeler, Seconded by Dr. I. H. Beckman: "THAT the letter be referred to the Executive Committee for study and the necessary reply." Carried.

**8. Enquiries.****(a) Re Printing of By-Laws.**

The Registrar asked the advice of the Council regarding the printing of the revised by-laws. No action was taken.

**9. Notices of Motion.**

None.

**10. Motions of Which Notice Has Been Given at Previous Meetings.**

The following notice of motion was presented at the meeting of the Council on May 18th, 1945: "THAT section 29, subsection (a), paragraph 3 be amended by adding the following clause:

"or unless he was (a) licensed in a Province of Canada prior to 1925 and (b) has been in active, ethical practice and/or graduate study continuously since 1925."

**Motion:**

Moved by Dr. H. Bruce Chown, Seconded by Dr. T. Digby Wheeler: "THAT the above amendment to the by-laws be accepted." Carried.

**11. Unfinished Business from Previous Meetings.****(a) Re Representation on the Board of the Manitoba Medical Service.**

No action was taken in this matter, as Dr. T. Digby Wheeler's name had been nominated as a member of the Board of Trustees of the Manitoba Medical Service.

**12. Miscellaneous and New Business.****(a) Payment to Janitor.****Motion:**

Moved by Dr. T. Digby Wheeler, Seconded by Dr. H. O. McDiarmid: "THAT the janitor be paid Five Dollars (\$5.00) for his services at this meeting." Carried.

**Adjournment**

The meeting then adjourned.

**Registration Committee**

Winnipeg, Man., November 9, 1945.

A meeting of the Registration Committee was held in the Registrar's office, on Friday, November 9th, 1945.

Present: Drs. T. Digby Wheeler, Wm. Turnbull and W. G. Campbell.

**1. Consideration of an Application for Registration from Dr. Thomas Alphonsus Lebbetter.**

Dr. Lebbetter graduated in medicine from Dalhousie University in 1914, and became registered in the same year with the Nova Scotia Medical Board. He had practiced as a specialist in internal medicine at Yarmouth, N.S., from 1932-1942, during which time he had held positions as President of the Nova Scotia Medical Society, Representative on the Nova Scotia Medical Board, Medical Consultant to the Army and Air Force 1939-1942 for Western Nova Scotia, Medical Consultant to the R.C.A.M.C. for internal medicine for Eastern Canada during the war 1939-1945. Dr. Lebbetter is registered with the General Medical Council of Great Britain by virtue of reciprocal relationship between the Nova Scotia Medical Board and the General Medical Council of Great Britain.

By virtue of an amendment to By-Law No. 29, passed at the meeting of the Council of the College of Physicians and Surgeons of Manitoba on October 17, 1945, Dr. T. A. Lebbetter is eligible for registration with the College of Physicians and Surgeons of Manitoba.

**Motion:**

Moved by Dr. T. Digby Wheeler, Seconded by Dr. Wm. Turnbull: "THAT Dr. Thomas Alphonsus Lebbetter's application for registration be accepted." Carried.

**2. Consideration of an Application for Registration from Dr. Walter Campbell MacKenzie.**

Dr. MacKenzie is a graduate from Dalhousie University in 1933, and is licensed with the Medical Council of Canada the same year. He is registered with the College of Physicians and Surgeons of Alberta under date of February 4, 1938.

**Motion:**

Moved by Dr. Wm. Turnbull, Seconded by Dr. T. Digby Wheeler: "THAT Dr. Walter Campbell MacKenzie's application for registration be accepted." Carried.

**3. Consideration of an Application for Registration from Dr. Leonard Ernest Lotimer.**

Dr. Lotimer is a graduate from Toronto University in 1937, and is licensed with the Medical Council of Canada the same year, and registered with the College of Physicians and Surgeons of Ontario under date of June 27, 1938.

**Motion:**

Moved by Dr. T. Digby Wheeler, Seconded by Dr. Wm. Turnbull: "THAT Dr. Leonard Ernest Lotimer's application for registration be accepted." Carried.

**4. Consideration of an Application for Registration from Dr. Henri Schaffer.**

At a meeting of the Council of the College of Physicians and Surgeons of Manitoba held on October 17, 1945, the minutes of a previous meeting of the Registration Committee, under date of September 21, 1945, were passed, in which a resolution stated that European graduates in medicine, who have been employed in the Province of Manitoba, by the Provincial Health Department, could attend the fourth year examination, could then apply to the College of Physicians and Surgeons for an enabling certificate to write the examination of the Medical Council of Canada.

On October 22, 1945, Dr. Schaffer was informed of this resolution in the office of the Registrar, and was also shown a copy of same as passed as stated above, and was advised to comply with the requirements, as outlined. He claimed that he was financially unable to comply with these requirements, and removed all his documents, personally, from the Registrar's office.

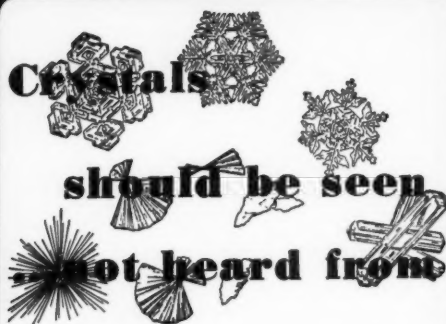
**Motion:**

Moved by Dr. T. Digby Wheeler, Seconded by Dr. Wm. Turnbull: "THAT Dr. Henri Schaffer's file be closed." Carried.

**5. Re Assad Jarrah Zade.**

An enabling certificate was issued to Dr. Zade on January 14, 1942. He has failed on various occasions on the examination of the Medical Council of Canada.

On account of difficulties which Dr. Zade has had with the Immigration Department, and his



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failure to carry out instructions to attend the Manitoba Medical College, the Registration Committee, at a meeting on November 8, 1944, passed the following resolution: "THAT this Committee rescind the action of the Registration Committee, under date of January 14, 1942, and withdraw its consent to the formerly issued enabling certificate." Carried.

The action of the Committee was confirmed by the Council at a meeting held on May 18th, 1944. Unfortunately, Dr. J. Fenton Argue, Registrar of the Medical Council of Canada, was not informed of this action of the Council.

#### Motion:

Moved by Dr. W. G. Campbell, Seconded by Dr. Wm. Turnbull: "THAT Dr. J. Fenton Argue be notified of the action of the Registration Committee and the Council, as stated above, and that he be asked to cancel the enabling certificate, and to return the same to this office." Carried.

#### Registration Committee

Winnipeg, Man., November 27, 1945.

A meeting of the Registration Committee was held in the Registrar's office, on Friday, November 27th, 1945.

Present: Drs. Wm. Turnbull, T. Digby Wheeler and W. G. Campbell.

#### 1. Consideration of an Application for Registration from Dr. Peere Caroe Lund.

Dr. Lund graduated from the University of Alberta in 1940, and is a licentiate of the Medical Council of Canada the same year. He was commissioned with the Royal Canadian Air Force in 1941.

#### Motion:

Moved by Dr. T. Digby Wheeler, Seconded by Dr. Wm. Turnbull: "THAT Dr. Peere Caroe Lund's application for registration be accepted." Carried.

#### 2. Consideration of an Application for Registration from Dr. John Wendell Macleod.

Dr. Macleod is a graduate from McGill University in 1930. He is registered with the Medical Council of Canada under date of July 7, 1931, and is registered in the Province of Quebec in 1930. He has served in the recent war as Surgeon Commander.

#### Motion:

Moved by Dr. T. Digby Wheeler, Seconded by Dr. Wm. Turnbull: "THAT Dr. John Wendell Macleod's application for registration be accepted." Carried.

#### 3. Consideration of an Application for Registration from Dr. Jessie Anna Evelyn McGeachy.

Dr. McGeachy is the wife of Dr. J. W. Macleod. She is a graduate from the University of Toronto in 1937, and a licentiate with the Medical Council of Canada the same year. She is registered with the Province of Ontario in 1938.

**Motion:**

Moved by Dr. T. Digby Wheeler, Seconded by Dr. Wm. Turnbull: "THAT a license be granted to Dr. Jessie Anna Evelyn McGeachy." Carried.

**4. Consideration of an Application for Registration from Dr. Kenneth George Smith Davidson.**

Dr. Davidson is a graduate from Edinburgh University of 1943, and is registered with the General Medical Council of Great Britain in 1943.

**Motion:**

Moved by Dr. T. Digby Wheeler, Seconded by Dr. Wm. Turnbull: "THAT a license be granted to Dr. Kenneth George Smith Davidson." Carried.

**5. Consideration of the Applications for Registration from Dr. Albert Lecot, Dr. Grant Elliott Colpitts, and Dr. Frank John Squires.**

The above named have been graduated from the University of Manitoba as of October, 1945. All three above named failed in their examination of the Medical Council of Canada. All three have been commissioned in the army, and are proceeding to Camp Borden for basic training. The Department of Defence are requesting that these three be issued licenses to be dated November 14, 1945.

**Motion:**

Moved by Dr. T. Digby Wheeler, Seconded by Dr. Wm. Turnbull: "THAT Dr. Albert Lecot, Dr.

Grant Elliott Colpitts, and Dr. Frank John Squires be granted licenses to be dated November 15, 1945." Carried.

**Registration Committee**

Winnipeg, Man., January 4, 1946.

A meeting of the Registration Committee was held in the Registrar's office on Friday, January 4, 1946.

Present: Drs. Wm. Turnbull and W. G. Campbell.

The purpose of the meeting was to consider the application for an enabling certificate from Dr. Lorne Eckhardt Brown. Dr. Brown is a graduate from the University of Tennessee, which according to the American Register, is a Class A school. Dr. Brown is applying for an enabling certificate to write the examination of the Medical Council of Canada to become registered with the College of Physicians and Surgeons of Manitoba, and through Reciprocity with the General Medical Council of Great Britain, become registered there, for the purpose of carrying on missionary work in some British possession.

**Motion:**

Moved by Dr. Wm. Turnbull, Seconded by Dr. W. G. Campbell: "THAT Dr. Lorne Eckhardt Brown be granted an enabling certificate." Carried.

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\*Co Tui et al. *Journal Am. Gast. Soc.* July 1945.



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# Manitoba Medical Service

## BALANCE SHEET AT DECEMBER 31, 1945

ASSETS		
CASH AT BANKS:		
Current Accounts		\$ 11,963.19
(Available to meet operating expenses)		
CASH ON HAND		25.00
ACCOUNTS RECEIVABLE:		
Manitoba Hospital Service Association	\$ 23,231.15	
Subscriptions in process of collection	10,556.43	33,787.58
(December Collections paid over in January)		
FURNITURE, FIXTURE AND OFFICE EQUIPMENT		1.00
DEFICIT ACCOUNT:		
Excess of Expenses over Income for the period from incorporation to 31st December, 1945, per Statement 11		4,557.36
		<u>\$ 50,334.13</u>
LIABILITIES		
ACCOUNTS PAYABLE:		
Accounts of Medical Members	\$ 36,342.97	
(Accounts for services given in December)		
Sundry Accounts Payable	3,356.16	\$ 39,699.13
(Payable in January)		
DEFERRED INCOME:		
Unearned Subscribed Payments		4,135.00
DEFERRED LIABILITIES:		
Manitoba College of Physicians and Surgeons	\$ 5,000.00	
Manitoba Medical Association	1,000.00	
Winnipeg Medical Society	500.00	6,500.00
		<u>\$ 50,334.13</u>

## STATEMENT OF INCOME AND EXPENSES FOR THE PERIOD FROM INCORPORATION TO 31st DECEMBER, 1945

INCOME:		
Earned Subscriptions	\$225,760.12	
Sundry	1,340.49	\$227,100.61
EXPENSES:		
Accounts of Subscribers and Dependents	\$283,098.63	
Less amounts absorbed by Medical Members of the Service	90,100.35	192,998.28
Administration fee paid to Manitoba Hospital Service Association		19,214.00
Operating Expenses		18,593.79
Furniture, Fixtures and Office Equipment		851.90
		<u>231,657.97</u>
EXCESS OF EXPENSES OVER INCOME:		
Carried forward to Statement 1		4,557.36

Approved on behalf of the Board of Trustees: A. C. ABBOTT, M.D.

### AUDITOR'S REPORT

To the Board of Trustees, Manitoba Medical Service, Winnipeg, Manitoba.

We have audited the books of the Manitoba Medical Service for the period from incorporation to 31st December, 1945, and we report that we have obtained all the information and explanations we required and that, in our opinion, the Balance Sheet and accompanying Statement of Income and Expenses are properly drawn up so as to exhibit a true and correct view of the state of the Service's affairs at 31st December, 1945, and the results of its operations for the period from incorporation to 31st December, 1945, according to the best of our information and the explanations given, and as shown by the books of the Service. All the transactions of the Service that have come within our notice have been within the objects and powers of the Service, to the best of our information and belief.

GEORGE A. TOUCHE & COMPANY, Chartered Accountants.  
Auditors.

April 5th, 1946.

### MEMBERSHIP AS AT 31st DECEMBER, 1945

Subscribers, 11,553. Dependents, 13,789. Total Participants, 25,342.

### OFFICERS OF THE BOARD

M. R. MacCharles, M.D., Chairman. Mr. Robert MacKay, Vice-Chairman.  
H. Cameron, M.D., Secretary. A. C. Abbott, M.D., Treasurer.

E. S. Moorhead, M.D., Medical Director

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